Mercer

Government Human Services Consulting

Proprietary and Confidential

Final Report

Community HealthChoices Managed Care Program Calendar Year 2020 Encounter and Financial Data Triennial Audit

Commonwealth of Pennsylvania
Department of Human Services
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Contents

1. Executive Summary

1.1. Purpose

The 2016 Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (42 § Code of Federal Regulation [CFR] 438.602[e]) requires state Medicaid programs to conduct an encounter and financial data audit, of data submitted by or on behalf of managed care organizations (MCOs), no less frequently than once every three years. The purpose of this regulation is to ensure high quality encounter and financial data for managed care capitation rate development, risk adjustment, program monitoring/oversight, and other data analytic needs.

In addition to the federal regulations, the United States Department of Health and Human Services, Office of Inspector General (OIG) has published multiple reports with adverse findings on the quality of data that the Centers for Medicare & Medicaid Services (CMS) receives from state Medicaid agencies. OIG's most recent report from March 2021[1] emphasized the importance of high-quality encounter data for rate setting and CMS' responsibilities for oversight of state Medicaid programs, identifying trends to drive policy making, and detecting fraud, waste, and abuse (FWA).

> "Access to high-quality, timely data is essential for ensuring robust monitoring and oversight of Medicaid programs and CMS has made improving Medicaid data a top priority."
> Centers for Medicare & Medicaid Services (CMS) response to OIG March 2021 findings

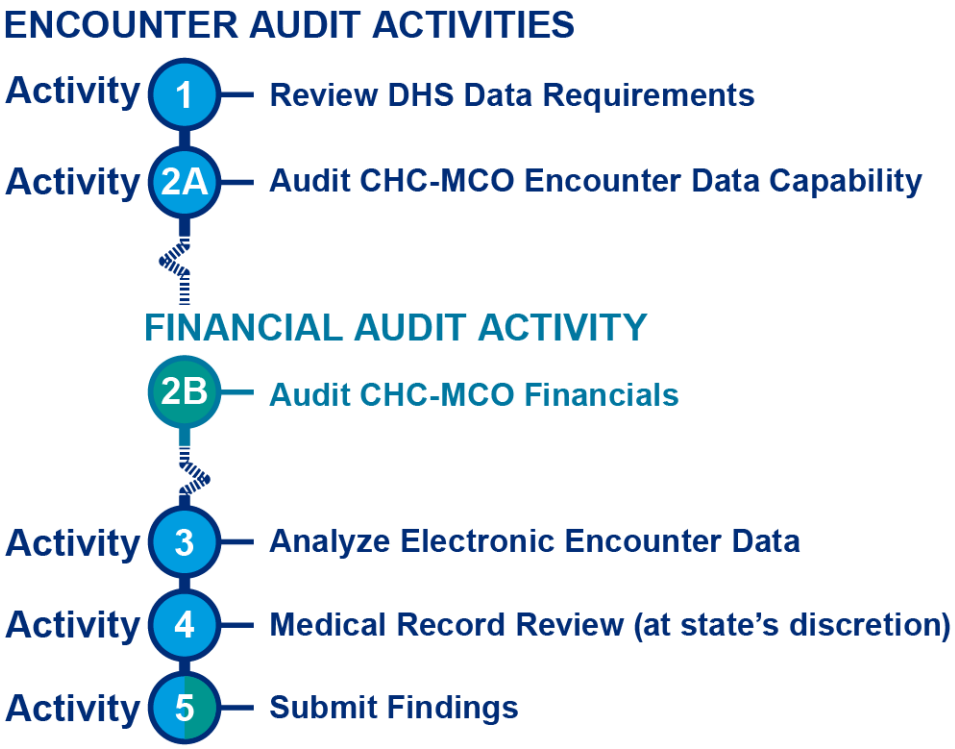
The Commonwealth of Pennsylvania (Commonwealth), Department of Human Services (DHS) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to conduct an audit of the Community HealthChoices (CHC) program designed to comply with this requirement. Mercer worked with DHS Office of Long-Term Living (OLTL) staff to perform the audit of encounter and financial data activities for Calendar Year (CY) 2020. We use the terms DHS and OLTL, in reference to OLTL staff and processes supporting the CHC program, interchangeably throughout this report.

1.2. Approach

Mercer's approach to this audit leveraged CMS' External Quality Review (EQR) Protocol #5 for encounter data validation (EDV)[2]. The CMS EDV protocol includes five activities, which guided Mercer's methodology and procedures. Each of these activities is described in detail in subsequent sections of this report.

[1] United States Department of Health and Human Services, OIG Data Brief OEI-02-19-00180. March 2021. Available at: Data on Medicaid Managed Care Payments to Providers Are Incomplete and Inaccurate OEI-02-19-00180 03-26-2021 (hhs.gov). Last accessed on November 9, 2021.

[2] https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.



1.3. Results

The objective for each activity is summarized below, alongside summary level results for that activity.

Activity 1: Review DHS Data Requirements

Activity 1 Objective: Assess DHS' encounter and financial data processes, reporting requirements, and guidance to CHC-MCOs.

In the EDV Toolkit, CMS describes the following foundational activities states should undertake to ensure high-quality data.

- Encounter Data Management Staff
- Contractual Requirements
- Encounter Submission Standards and Guidance
- Financial Incentives and Penalties
- Validation and Feedback to MCOs

Mercer assessed DHS' capabilities across these five foundational activities to determine whether DHS provides sufficient support to ensure accurate and timely encounter data. The following summarizes the overall results of our Activity 1 assessment.

ACTIVITY 1 RESULTS

The systems capabilities and day-to-day encounter data oversight and monitoring DHS performs on behalf of the CHC program aligns with, and in some cases exceeds, the standards currently outlined in federal regulations and related CMS guidance.

Mercer did not observe any opportunities to enhance DHS' current communication processes or day-to-day encounter operations. However, while an audit of 200 sample encounter records is required by the CHC-MCO contract, DHS has yet to perform this audit. CMS states in the EDV Toolkit that states should implement penalties and incentives as outlined in their contracts with MCOs. Therefore, DHS should consider completing the audit per existing contract terms.

Activity 2A: Review CHC-MCO Data Capability

Activity 2A Objective: Evaluate the CHC-MCO's ability to submit complete, accurate, and timely encounter data.

Mercer assessed the CHC-MCOs' capabilities in the following areas:

- Claims and Encounter Data Systems
- Management of Claims and Encounters
- Encounter Monitoring

To ensure a consistent evaluation across the CHC-MCOs, Mercer established standardized evaluation criteria and distributed a Request for Information (RFI) to the CHC-MCOs to collect relevant information. We analyzed the information the CHC-MCOs submitted against the evaluation criteria and conducted virtual on-site reviews to confirm our understanding and analysis of the information they submitted, clarify any outstanding questions, and identify any necessary follow-up items.

The following summarizes the overall results of our Activity 2A assessment.

ACTIVITY 2A RESULTS

All CHC-MCOs have sufficient systems, processes, policies, and personnel to successfully monitor encounter data submission and ensure accurate and timely encounter data are available to the State to use for capitation rates, quality measurement, program integrity, and policy development. However, several opportunities for improvement were identified that could strengthen individual CHC-MCO practices and clarify DHS expectations going forward.

Activity 2B: Audit CHC-MCO Financials

Activity 2B Objective: Assess the accuracy, completeness, and truthfulness of contractually required financial schedules used in the capitation rate-setting process.

Mercer focused this audit on financial data used by Mercer actuaries as a critical part of the CY 2022 capitation rate development process. Specifically, the audit is designed to ensure the data are appropriate for rate setting and are consistent with the encounter data reported through PROMISe™.

The CHC-MCO financial schedules are subject to an examination by the CHC-MCO Independent Public Accountant (IPA), which includes the following contractually required financial schedules utilized in rate setting.

- Report #4 — Lag Reports
- Report #5 — Income Statements (this Report includes Report #1 — member month data)
- Report #14 — In-Lieu of Services Summary Report
- Report #15 — Expanded/Value-Added Summary Report
- Report #42 — Medical Loss Ratio Reporting

In addition to reviewing the results of this examination for each CHC-MCO, Mercer developed a comparison of encounters to Report #4 to determine their consistency.

ACTIVITY 2B RESULTS

In CY 2020, there were no findings identified by the IPAs with the CHC-MCO financial submissions. Statewide across all CHC-MCOs, submitted encounters support 98.3% of reported financial statement data.

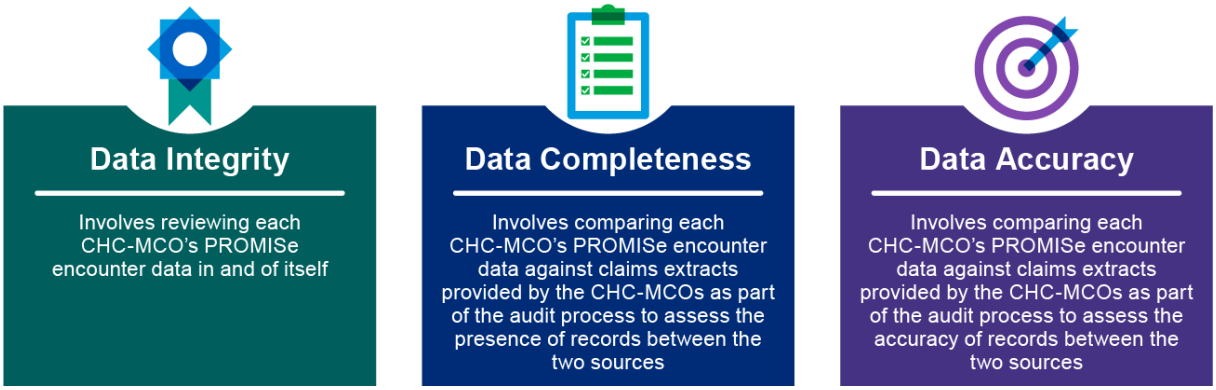
Activity 3: Analyze Electronic Encounter Data

Activity 3 Objective: Assess electronic encounter Data Completeness and Data Accuracy, with a focus on data elements affecting capitation rate development.

A major component of Activity 3 involves comparing the claims data extracts submitted by the CHC-MCOs as part of this audit to the PROMISe encounter data extract. Consistent with other review activities, Mercer used the CMS protocol as a framework to complete the data analytics.

Mercer analyzed the PROMISe encounter data to assess Data Integrity, Data Completeness, and Data Accuracy in accordance with the data test plan, focusing on select data fields that inform or influence capitation rate development and performed these analyses separately for the following claim forms: Institutional (including PROMISe Inpatient and Outpatient), Professional, and Pharmacy.

We organized analytics performed during this activity into three categories based on recommendations included in CMS' EDV Protocol #5. These included the following:



OVERALL RESULTS

For each of the major categories of analyses Mercer conducted, we found the following:

- Overall, the program displays an expected degree of encounter data quality given that CY 2020 represents the first year of statewide program implementation.
- Most fields in the CHC encounter data which are expected to be populated are populated in a high number of instances. When fields are able to be assessed for reasonability, they generally contain reasonable values.
- An acceptable degree of matching records was observed for Professional and Pharmacy claim forms for all CHC-MCOs and for Institutional claim forms for two of three CHC-MCOs.
- The accuracy of CHC encounter data could be improved for all CHC-MCOs.
- We discovered several issues with UPMC's Institutional data that DHS should further investigate to understand the scope of the issue. This compromised the audit's ability to produce meaningful conclusions for UPMC Nursing Facility records, a major source of program cost.

Activity 4: Medical Record Review

Activity 4 was not included in the scope of this audit; it is optional under the CMS protocol.

Encounter Data Activity 5: Submit Findings

Activity 5 Objective: Develop a report outlining the audit methodology, key observations, and resulting documentation.

On behalf of DHS, Mercer developed this report, which describes the analyses we performed as part of the audit, displays results, and outlines key observations for review and consideration by DHS. Specifically:

- **Section 3** of this report identifies areas within DHS' encounter data requirements and guidance to CHC-MCOs that could be strengthened.
- **Section 4** highlights CHC-MCO-specific observations and provides recommendations related to potential improvement areas.
- **Section 5** highlights findings from our comparison of CHC-MCO financial and encounter data.
- **Section 6** summarizes the results of our data analytics and outlines observations for review by DHS.

DHS will post a summary of these audit results on its website.

1.4. Key Recommendations

Based on the audit results described above, Mercer provides the following key recommendations for DHS to consider.

Table 1-1: Key Recommendations

Audit Activity	Recommendation
Activity 1: Review DHS Data Requirements	DHS' contract with the CHC-MCOs requires an audit of at least 200 sample encounter records to assess Data Completeness and Data Accuracy; however, DHS does not currently complete that audit. DHS should consider completing the audit per existing contract terms.
Activity 2A: Review CHC-MCO Data Capability	The Workgroup for Electronic Data Interchange Strategic National Implementation Process (SNIP) edits apply industry-standard verification of claims at seven levels. While all CHC-MCOs perform SNIP-level edits, UPMC applies them only at levels 1 and 2. Furthermore, UPMC reported approximately 40% of all claims are pended for additional review. Although DHS does not require use of SNIP edits, UPMC should consider application of additional SNIP edits to increase auto-adjudication rates and reduce manual tasks and interventions.
	UMPC's national provider identifier (NPI) application process creates the risk that a billing provider's NPI and Taxonomy codes differ between the outbound encounter and the inbound claim. UPMC should consider

Audit Activity	Recommendation
	revising its NPI application process to ensure the billing provider's NPI on the encounter is sourced directly from the claim.
	PHW reported loading fee schedules quarterly or as listed in the bulletin posted by the Commonwealth; however, the Commonwealth updates some fee schedules on a more frequent basis (e.g., monthly). While not required by DHS, PHW should consider updating its fee schedule monthly to further ensure compliance with the most recent fee schedules.
	Each CHC-MCO reported very different audit processes. UPMC appeared to have the most robust process of the three. PHW reported sampling a much smaller number of claims, and PHW did not provide the information Mercer requested related to its audit approach. Given the different audit approaches, CHC-MCOs may benefit from more direction from DHS on audit techniques and sample sizes to ensure their performance and audit findings are consistent and meet expectations.
Activity 3: Analyze Electronic Encounter Data	In evaluating Data Completeness — the extent to which records are shared in the PROMISe data and CHC-MCO extract — the Pharmacy claim form showed a lower than expected shared rate. Mercer recommends DHS conduct additional investigation into the cause of the missing and surplus records identified for the Pharmacy claim form to understand if the results reflect an isolated issue related only to data sets in this audit or if there may a more systemic issue related to Pharmacy data.
	Mercer identified significant issues in UPMC's Institutional data in both the Inpatient and Outpatient sub-types. Specifically, $981 million in PROMISe Inpatient encounters did not match to data in the UPMC extract, and Mercer was unable to identify Institutional long-term care claims in the data. Additionally, significant irregularities were identified in the Detail Amount Paid submitted on UPMC's Outpatient claims data, while amounts at the header level were more consistent with the PROMISe data. Mercer recommends DHS conduct additional investigation into the data irregularities identified for UPMC to understand if the results reflected in the audit are an isolated issue related only to data sets in this audit or if there may be a more systemic issue related to UPMC's Institutional data.

1.5. Overall Impressions

Mercer's qualitative findings from the CHC encounter and financial data audit suggest DHS generally has the systems and processes in place to appropriately monitor and ensure the quality of encounter data. Additionally, each CHC-MCO has the systems and capabilities to generate timely and accurate encounter data. The results of our assessment of the encounter and claims data provided for this audit were variable and, in some cases, inconclusive. While some assessment areas — such as Population Integrity and Reasonableness Integrity — showed strong results, there are several areas in which we suggest DHS conduct additional investigation to determine whether the results of this

analysis are driven by one-time issues associated with the data provided for this audit or are representative of larger systemic issues.

As noted earlier, CHC is a relatively new managed care program, and the time period for this audit (CY 2020) corresponds to the first year of full program implementation. As with the implementation of any new program, complications inevitably arise, especially with respect to data. The results of this report should be considered in that context and with the understanding that DHS and the CHC-MCOs are continually assessing and implementing processes and systems for performance improvement as the program matures. It is Mercer's impression that the CHC program presents acceptable encounter data monitoring processes and expected complications with encounter data quality given its maturity.

1.6. Limitations and Use

This encounter and financial data audit of the CHC program has been informed, designed, and conducted in accordance with CMS EQR Protocol #5 to provide DHS with reasonable assurance that the encounter data received from CHC-MCOs is complete, accurate, and timely, that DHS' processes for the management of encounter data are robust and adhere to CMS recommendations, and that the contracts with CHC-MCOs ensure downstream regulatory compliance. That said, while this audit meets certain compliance requirements and works toward improved data quality and increased program transparency, there are certain inherent limitations which DHS should be aware of when reviewing this report and considering with the implementation of resultant recommendations. Mercer has provided detail regarding these limitations within the body of this report.

This report is prepared on behalf of DHS and is intended to be relied upon by DHS. To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

The suppliers of data are solely responsible for its validity and completeness. Mercer has reviewed the data and information for internal consistency and reasonableness utilizing CMS EDV protocols and guidance, but validation of each encounter and data element against source systems and medical records was not within the scope and timing of the audit objectives. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events, and actual experience will vary from estimates.

Mercer expressly disclaims responsibility, liability, or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

2. Audit Background and Approach

2.1. Background

The 2016 Medicaid and CHIP Managed Care Final Rule includes a requirement for state Medicaid programs to conduct an encounter and financial data audit at least once every three years of the data submitted by, or on behalf of, each MCO, Prepaid Inpatient Health Plan, or Prepaid Ambulatory Health Plan. Once complete, audit results must be posted to the State's website.

42 § CFR 438.602(e) indicates that states must conduct periodic audits (no less frequently than once every three years) for accuracy, truthfulness, and completeness of encounter and financial data and 42 § CFR 438.602(g) requires results of the audit be posted to the State's website.

Requirements outlined in 42 § CFR 438.602(e) apply to managed care contracts with a July 1, 2017 effective date or later. CMS' implementation of this requirement is intended to ensure states are regularly monitoring the quality of their managed care encounter data and working with MCOs to achieve high levels of encounter data validity and completeness. This allows CMS and states to confidently rely on encounter data for a wide range of purposes including capitation rate development, risk adjustment, program monitoring and oversight, and various other data analytic needs.

To meet this Managed Care Final Rule requirement, DHS contracted with Mercer to conduct an EDV audit on the CHC managed care program administered by OLTL.

CHC Program

CHC is Pennsylvania's mandatory managed care program for adults 21 years and over who have both Medicare and Medicaid coverage or are receiving long-term services and supports (LTSS) through certain waiver programs or in a nursing home. The CHC program covers the same physical health services included in the HealthChoices Physical Health (HC PH) program as well as LTSS for eligible participants. The CHC program does not cover behavioral health services, which are covered through the HealthChoices Behavioral Health program.

The Department of Human Services (DHS) staggered the implementation of CHC across the Commonwealth, beginning in the Southwest Region in January 2018. DHS implemented CHC in the Southeast Region in January 2019 and throughout the rest of the Commonwealth in January 2020.

Three CHC-MCOs serve participants throughout the Commonwealth:

- AmeriHealth Caritas (AHC)
- PA Health & Wellness (PHW)
- UPMC Community HealthChoices (UPMC)

AHC and UPMC have also participated in the HC PH program for many years, while PHW has only participated in Pennsylvania Medicaid managed care since the inception of CHC in 2018.

While not always the case for newly implemented Medicaid managed care programs, DHS relies heavily on encounter data to manage and administer many aspects of the CHC program.

2.2. Encounter Data Approach

To align with regulatory guidelines and ensure consistency in assessment criteria, Mercer employed an audit methodology based on CMS EQR Protocol #5 for EDV. The following graphic outlines the major steps included in the CMS EQR Protocol #5 for EDV.

Please note that in addition to the Encounter Data Audit activities, Mercer also performed a review of financial report submissions, which we describe in Section 2.3 below.

Objectives and Methodology

Below we describe each of the EDV activities, including the objective for each and a brief overview of the methodology Mercer employed to achieve that objective.

Encounter Data Activity 1: Review DHS Data Requirements

Activity 1 Objective: Assess DHS' encounter and financial data processes, reporting requirements, and guidance to CHC-MCOs.

To complete the Activity 1 objective, Mercer reviewed documentation completed by DHS personnel to assess the relevant processes, requirements, and guidance. We based our approach for the Activity 1 assessment on guidance provided by CMS. Specifically, CMS issued EQRO Protocol #5 — Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan (EDV protocol) and, subsequently, in August 2019, CMS also

published the State Toolkit for Validating Medicaid Managed Care Encounter Data[3] (EDV Toolkit). This toolkit describes the foundational activities all states should perform to ensure high quality data and summarizes some states' best practices.

Mercer has a robust understanding of DHS' encounter and financial data standards, reporting, and supporting documents resulting from our long history of working with DHS' encounter and financial data. However, to ensure Mercer reviewed complete and up-to-date encounter-related documents, we developed and distributed an RFI to obtain additional information from DHS. In addition to assessing DHS' processes, requirements, and guidance to CHC-MCOs, Mercer also assessed each CHC-MCO's understanding of DHS requirements.

Mercer's observations and recommendations resulting from the review of DHS processes are in Section 3 of this report.

Encounter Data Activity 2A: Review CHC-MCO Data Capability

Activity 2A Objective: Evaluate the CHC-MCO's ability to submit complete, accurate, and timely encounter data.

To achieve the Activity 2 objective, Mercer's approach included four key steps:

- Establish evaluation criteria
- Develop and distribute an RFI to collect relevant information from the CHC-MCOs
- Analyze information submitted by CHC-MCO
- Conduct virtual on-site reviews

Establish Evaluation Criteria

To standardize reviews across all three CHC-MCOs, Mercer developed evaluation criteria based on industry standards and best practices for ensuring high quality encounter data. These criteria included the assessment of information systems, data acquisition and exchanges, vendor oversight, encounter file processing, security, and business continuity and disaster recovery (BCDR). Besides guiding the audit approach, they also informed our review of CHC-MCO RFI responses and the virtual on-site reviews, as well as the quantitative results produced as part of the data analysis portion of the audit (described in Section 6).

Develop and Distribute an RFI

In alignment with CMS EQR protocols, Mercer developed a CHC-MCO RFI based on the Information Systems Capabilities Assessment tool referenced in the CMS EDV protocol. Questions in the RFI focused on operations and systems specific to claims, encounters, and financials, along with the CHC-MCO's adherence to DHS' encounter data submission

[3] State Toolkit for Validating Medicaid Managed Care Encounter Data. August 2019. Available at: State Toolkit for Validating Medicaid Managed Care Encounter Data. Last accessed on November 17, 2022.

requirements. DHS sent the RFI to the CHC-MCOs in August 2022 to complete and submit to Mercer by September 2022. The RFI also included self-reported attestation questions to further enhance Mercer's understanding of the CHC-MCO processes and systems.

Analyze Information Submitted by CHC-MCOs

Mercer completed a desk review of the CHC-MCO RFI responses and supporting documentation, comparing the submitted information against the established evaluation criteria. Based on this review, Mercer prepared agendas for discussions with the CHC-MCOs designed to obtain additional information on any areas where the RFI responses were unclear, appeared lacking, or indicated potential non-compliance.

Conduct Virtual On-Site Reviews

Mercer then conducted a virtual on-site review with key personnel from each CHC-MCO to obtain an understanding of their information systems and processes, as explained in their RFI responses. Mercer organized the virtual on-site meeting agendas as follows:

- Confirm Mercer's understanding of the submitted information
- Ask clarifying questions
- Identify any follow-up requests

The results of Mercer's review of each CHC-MCO is contained in Section 4 of this report.

Encounter Data Activity 3: Analyze Electronic Encounter Data

Activity 3 Objective: Assess electronic encounter Data Completeness and Data Accuracy, with a focus on data elements affecting capitation rate development.

To accomplish the objective of Activity 3, Mercer conducted a series of analyses of CY 2020 encounter data. Mercer established a data analytics approach based on information learned through Activities 1 and 2, discussions with DHS, and our nationwide experience with Medicaid encounter data.

Data Sources

Mercer established two CY 2020 encounter data sources for this Activity.

- **PROMISe data** — Mercer used the CY 2020 encounter data extract received regularly from DHS.
- **CHC-MCO data** — Mercer developed a data request for the CHC-MCOs to provide a CY 2020 claims data extract from each of their systems. Mercer requested claims data fields consistent with encounter fields CHC-MCOs submit to DHS' PROMISe system.

Comparing data from the PROMISe system and the CHC-MCO claims processing systems represents the best method for determining whether Pennsylvania's encounters are corroborated by and faithfully represent the information contained in the CHC-MCOs' in-house claims processing systems.

Data Analytics Approach

The data analytics approach included steps to evaluate the PROMISe encounter data extract in and of itself, as well as to compare this encounter data extract against the CHC-MCO claims system extracts provided in accordance with Mercer's standardized request.

We performed these analytics separately for Institutional, Professional, and Pharmacy claim forms, and organized them as follows.

- **Data Integrity**: Assess the PROMISe encounter data extract to determine:
  - *Population Integrity:* Measures the rate at which certain fields within the PROMISe encounter data extracts are populated.
  - *Reasonableness Integrity*: For certain populated fields, measures the rate at which these fields are populated with values that conform to national standards.
- **Data Completeness:** Assess the rate at which header-level encounter records can be matched between the PROMISe and CHC-MCO data sources.
- **Data Accuracy:** Assess the rate at which populated fields in both data sources match.

A detailed description of our methodology, along with a summary of results and observations, is in Section 6 of this report.

Encounter Data Activity 4: Medical Record Review

The CMS EDV protocol leaves it to the state to determine when a medical record review is appropriate. Activity 4 was not included in the scope of this audit.

Encounter Data Activity 5: Submit Findings

Activity 5 Objective: Develop a report outlining the audit methodology, key observations, and resulting documentation.

On behalf of DHS, Mercer developed this report, which describes the analyses we performed as part of the audit, displays results, and outlines key observations for review and consideration by DHS. Specifically,

- **Section 3** of this report identifies areas within DHS' encounter data requirements and guidance to CHC-MCOs that could be strengthened.
- **Section 4** highlights CHC-MCO-specific observations and provides recommendations related to potential improvement areas.
- **Section 5** highlights findings from our comparison of CHC-MCO financial and encounter data (described further in Section 2.3 below).
- **Section 6** summarizes the results of our data analytics and outlines observations for review by DHS.

DHS will post a summary of these audit results on its website.

2.3. Financial Data Approach

Activity 2B Objective: Assess the accuracy, completeness, and truthfulness of contractually required financial schedules used in the capitation rate-setting process.

Mercer focused the audit on specific financial data used by Mercer actuaries as a critical part of the capitation rate development process. The financial data audit, connected to Activity 2 in the EDV protocol and referred to as Activity 2B throughout this document, follows these steps.

Financial Data Step 1: Perform Risk Analysis

Mercer established risk criteria to determine which financial schedules should be included in this audit. Specifically, Mercer assessed the level to which each financial schedule impacts capitation rate development.

As a result of the risk analysis, Mercer identified four key schedules for potential inclusion in the audit:

- Report #4 — Lag Reports
- Report #5 — Income Statements (this Report includes Report #1 — member month data)
- Report #14 — In-Lieu of Services Summary Report
- Report #15 — Expanded/Value-Added Summary Report
- Report #42 — Medical Loss Ratio Reporting

Financial Data Step 2: Develop Audit Procedures

In Step 2, Mercer developed financial audit procedures. We leveraged information provided by the CHC-MCO IPA examination related to the identified reports. On the basis of the results of those examinations, we identified a methodology to compare Report #4 financial information to encounter data from the same time period to assess only those risk areas not deemed sufficiently addressed in the examinations.

Financial Data Step 3: Perform Audit Procedures

Mercer compared financial data from Report #4 and PROMISe encounter data for the same time-period. Mercer conducted analyses for the entire CHC program and by CHC-MCO (statewide and by zone).

The results of the Financial Audit are detailed in Section 5.

2.4. Limitations and Use

Mercer designed and conducted this encounter and financial data audit of the CHC program in accordance with CMS EQR Protocol #5 to provide DHS with reasonable assurance:

- The encounter data received from CHC-MCOs is complete, accurate, and timely.
- DHS' processes for the management of encounter data are robust and adhere to CMS recommendations.
- Contracts with CHC-MCOs ensure downstream regulatory compliance.

That said, while this audit meets certain compliance requirements and works toward improved data quality and increased program transparency, there are certain inherent limitations of which DHS should be aware when reviewing this report and considering the implementation of resultant recommendations.

This audit represents the first attempt by DHS to comply with new requirements issued by CMS for the CHC program. Any new process contains an inherent learning curve. As such, the following items have been noted that should be kept in mind during review of this report:

- CHC-MCOs may not be universally familiar with the many compliance updates, State Medicaid Director letter guidance, or EQR protocols issued by CMS related to this audit and its related regulations (e.g., 42 CFR § 438).
- The design of this audit has been influenced by CMS EQR Protocol #5, as recommended by CMS' EDV Toolkit. This represents a change from prior reviews of CHC-MCOs Mercer has performed on behalf of DHS. While two of the CHC-MCOs did undergo a similar audit under the HC PH program, one did not. Additionally, OLTL staff were not part of the HC PH audit. Therefore, some CHC-MCO and DHS staff are likely unfamiliar with some of the audit requests and procedures.
- While CMS has issued some guidance in the form of the EDV Toolkit and its reliance on the EQR Protocol #5, the toolkit merely states that EQR Protocol #5 is a path to performing a compliant Encounter Data and Financial Audit — the guidance does not explicitly mandate this approach, so other states in which CHC-MCOs operate may have followed different models.

- The scope of this audit involves a review of three separate entities in addition to the review of DHS. It involves integrating CHC-MCO claims data extracts for an entire year's worth of claims experience, sourced from at least three different claims systems. It involves reviewing financial source documentation from disparate accounting systems. Finally, it involves filtering of all that information through a single audit approach to ensure consistency in process and observations. In brief, this audit covers a lot: and as such, there are limitations on the depths to which its procedures can independently examine reported information.

In addition to navigating an audit approach which represents a change to previous reviews, DHS, the CHC-MCOs and Mercer faced the added complexity of participating in this audit 100% virtually. Mercer and the CHC-MCOs participated in the on-site reviews remotely, and most communications were electronic. While all participants made their best efforts to overcome these challenges, certain audit activities were more challenging than they may otherwise have been, particularly for the on-site portion of the audit.

The various limitations described above manifest differently depending on the audit activity in question. Moreover, specific procedures in each activity may themselves contain additional limitations important for DHS to consider during the review of this report. While this audit does include an examination of the degree to which the DHS-provided PROMISe encounter data extract files agree with the CHC-MCO-provided claims data extracts, the fact that this audit does not actually compare the two source systems should not be understated. The logistical impossibilities associated with independently auditing numerous unique and independent claims systems across several managed care programs are likely recognized by CMS, as EQR Protocol #5 assumes the use of extract files in the performance of this activity. Thus, DHS should be aware that any findings, observations, or recommendations arising from Activity 3 represent the results of comparing two snapshots of underlying data sources and could result from issues in the snapshots rather than the systems themselves.

The following is a high level visual of what this audit helps to answer and what it cannot guarantee.

Audit Activities	This Audit Helps Answer	This Audit Cannot Guarantee
1 Review DHS Data Requirements	• Is DHS adequately staffed to support encounter data quality? • Do CHC-MCO contracts contain required provisions?	• CHC-MCOs universally use resources provided by DHS • CHC-MCOs adhere to all contract requirements
2A Audit CHC-MCO Encounter Data Capability	• Do the CHC-MCOs describe appropriate training programs?	• All CHC-MCO staff adjudicate claims correctly • Physical access controls at offsite data centers function as described
2B Financial Audit	• Do PROMISe encounter paid amounts agree to FRR submissions? • Are non-allowed expenses appropriately excluded?	• Financial schedules are free of material misstatement • CHC-MCOs have appropriate documentation for all reported expenses
3 Analyze Electronic Encounter Data	• Do the values in fields within CHC-MCO claims extracts agree with those in PROMISe extracts? • Do field values meet DHS submission requirements?	• The CHC-MCO claims extract accurately represents in-house claims system(s) • PROMISe encounters are supported by patient medical records

Additionally, as described earlier, the CHC program is relatively new. DHS implemented the program in the Southwest Region in 2018 and reached full implementation in 2020. The data measurement period for this audit represents the first full year of CHC implementation. Moreover, in the implementation of any new managed care program, data issues are common and expected. In addition to the limitations described above, readers should consider findings in this report in the context of the relative maturity of the CHC program.

This report is prepared on behalf of DHS and is intended to be relied upon by DHS. To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

The suppliers of data are solely responsible for its validity and completeness. Mercer has reviewed the data and information for internal consistency and reasonableness utilizing CMS EDV protocols and guidance, but validation of each encounter and data element against source systems and medical records was not within the scope and timing of the audit objectives. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events, and actual experience will vary from estimates.

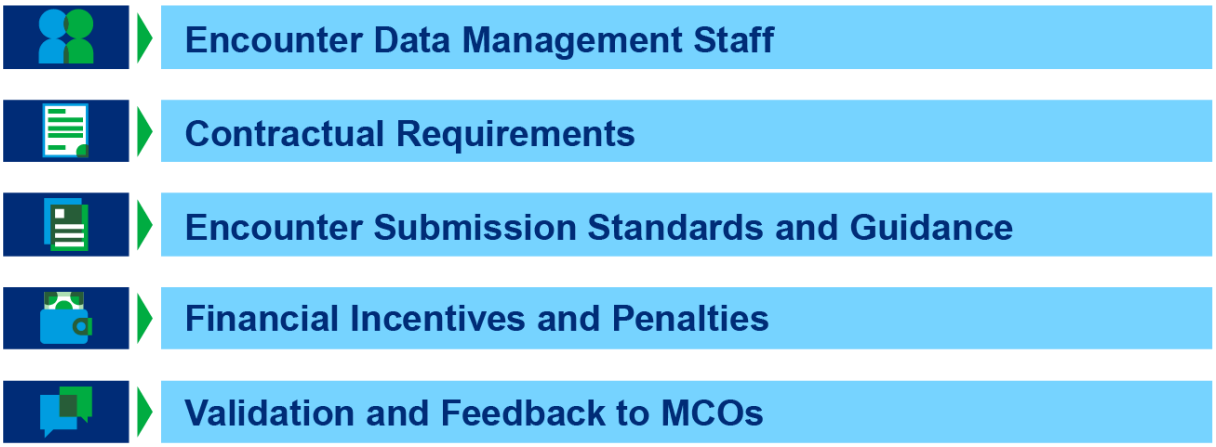
Mercer expressly disclaims responsibility, liability, or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

3. Activity 1: Review DHS Data Requirements

3.1. Objective

Activity 1 Objective: Assess DHS' encounter and financial data processes, reporting requirements, and guidance to CHC-MCOs.

As noted above, CMS issued the EDV Toolkit to provide practical information for states to validate and improve the Medicaid encounter data they receive from MCOs. In the EDV Toolkit, CMS describes foundational activities all states should perform to ensure high quality data and provides best practices states can implement related to these activities. These foundational activities are listed below.



Mercer assessed DHS' capabilities across these five foundational activities to determine whether DHS provides sufficient support to ensure accurate and timely encounter data.

3.2. Approach

While Mercer has a strong understanding of DHS' encounter data based on consulting work we have performed under our current and prior contracts with DHS, we developed and distributed an RFI to DHS to ensure we reviewed complete and up-to-date encounter-related documents. Specifically, we requested the most recent encounter data submission requirements, encounter Edit Codes and descriptions, Provider Specialty and Region Code crosswalks, system notices, and utilization reports.

Mercer reviewed these documents to assess DHS' encounter data requirements and engaged with DHS personnel, as needed, to obtain clarification. In addition to meeting the CMS requirement for assessing DHS' processes, requirements, and guidance to CHC-MCOs, this foundational knowledge enabled Mercer to assess each CHC-MCO's understanding of DHS requirements. Mercer's observations and recommendations resulting from the review of DHS processes are in Section 3.3 below.

3.3. Results

OVERALL RESULTS

The systems capabilities and day-to-day encounter data oversight and monitoring DHS performs on behalf of the CHC program aligns with, and in some cases exceeds, the standards currently outlined in federal regulations and related CMS guidance.

Mercer did not observe any opportunities to enhance DHS' current communication processes or day-to-day encounter operations. However, we did find that while an audit of 200 sample records is required by the CHC-MCO contract, DHS does not currently complete this audit. Moreover, CMS states in the EDV Toolkit that states should implement penalties and incentives as outlined in their contracts with MCOs. DHS should consider completing the audit per existing contract terms.

As noted above, the EDV Toolkit describes five foundational activities states should perform to ensure high quality encounter data. The following table summarizes Mercer's assessment of DHS' capabilities and processes along each of these five foundational activities.

Table 3-1: DHS Capabilities and Performance on Foundational Activities

Foundational Activity	DHS Capabilities and Performance
Encounter Data Management Staff	⊕
Contractual Requirements	●
Encounter Submission Standards and Guidance	●
Financial Incentives and Penalties	◒
Validation and Feedback to MCOs	◒

⊕ Exceeds ● Meets ◒ Partially Meets ○ Does Not Meet

Below we provide additional detail regarding Mercer's assessment for each foundational activity.

Encounter Data Management Staff

The EDV Toolkit indicates states should have at least one dedicated staff resource focused on encounter data quality and analysis, in addition to any external Medicaid management information system (MMIS) contractors. Additionally, the EDV Toolkit suggests state staff dedicated to encounter data quality and analysis should coordinate with other key state staff who use encounter data for program administration, oversight, and program integrity.

DHS exceeds the minimum staffing requirements outlined by CMS, and has several organizational areas with responsibility for management, analysis, and troubleshooting of encounter data. OLTL's organizational structure and staffing enables strong collaboration among internal stakeholders, CHC-MCOs, and other DHS Medicaid managed care program staff.

Contractual Requirements

The EDV Protocols and EDV Toolkit identify multiple items states should consider to determine if the MCOs are submitting high-quality encounters. These requirements may be driven by federal requirements and may be formalized in contractual language or companion guides.

DHS' contract with the CHC-MCO aligns with all federal requirements, as demonstrated in the table below.

Table 3-2: Compliance with Federal Requirements: Contract

Federal Requirement	Regulatory Reference	Included in CHC-MCO Contract?
States must require managed care plans to submit encounters using the ASC X12N 837 and National Council for Prescription Drug Program (NCPDP) formats and to use the ASC X12N 835 format as appropriate	42 CFR § 438.242[c][4]; 42 CFR § 438.242[b][3][iii]	✓
States must specify the timing of encounter data submission, including initial and corrected submissions	42 CFR § 438.242[c][2]	✓
States must require that leaders of managed care plans (for example, the CEO, CFO, or an authorized delegate) certify or attest that data submissions are complete and accurate	42 CFR § 438.606[a]	✓

Federal Requirement	Regulatory Reference	Included in CHC-MCO Contract?
States must require managed care plans to submit information about the servicing provider in encounter records	42 CFR § 242[c][1]	✓
States must require managed care plans to submit encounter data reports that comply with Health Insurance Portability and Accountability Act (HIPAA) standards	42 CFR § 438.818[a][1]	✓

Encounter Submission Standards and Guidance

In addition to federal requirements included in the table above, DHS included references in the Contract to ensure submission of timely, complete, and accurate encounter data. CMS' EDV Toolkit specifies encounter submission standards and guidance resources should include definitions, detailed expectations for the timing of submission, as well as standards for encounter Data Completeness and Data Accuracy.

DHS' contract with the CHC-MCO aligns with relevant federal requirements, as demonstrated in the table below.

Table 3-3: Compliance with Federal Requirements: DHS Documentation

Federal Requirement	Regulatory Reference	Included in DHS Documents?
States should provide detailed expectations for the format and schedule for data file submissions and all required data elements	42 CFR § 438.242[c][2] 42 CFR § 438.242[b][2] 42 CFR § 438.604[a][1]	✓
States should provide written procedures or quality assurance protocols to help managed care plans understand how the state will validate the submitted data	42 CFR § 438.242[d]	✓

Additional Recommended Elements

In addition to the items above, the EDV Toolkit makes additional recommendations, which DHS currently employs.

- **Terms and definitions:** To avoid ambiguity, the contract between DHS and the CHC-MCOs includes a section of the terms and definitions relevant to the administration of the program, including definitions for encounter data, claims, clean claim, eligibility files, and any other terms used in the contract.

- **Encounter data expectations:** The contract with the CHC-MCOs also stipulates the expectations for the completeness and accuracy of the encounter data. The requirement to submit complete and accurate encounter data extends to the providers and subcontractors with which the MCOs contracts.
- **Easily accessible guidance:** DHS provides access to different systems that contain guidance documents, data dictionaries, and companion guides.
- **Written data validation procedures:** DHS provides the CHC-MCOs with the U277 Encounter Transaction Guide to assist the CHC-MCOs in diagnosing and correcting their encounter denials. Discussions with the CHC-MCOs revealed that they use the information regularly to resolve encounter rejections.

Additional DHS Communication Tools

In addition to data dictionaries and compendia, DHS informs the CHC-MCOs about any vital information and shares materials with the CHC-MCOs using methods that include:

- Bulletins, newsletters, and website publications
- MMIS system notices regarding system changes, revisions and updates
- OLTL notices regarding billing changes and program changes

Financial Incentives and Penalties

Timely claims payment is critical to encounter Data Completeness. DHS sets specific requirements on the processing and payment of claims to ensure providers are paid on time. The contract includes requirements for timely submission and accuracy, and DHS may impose financial sanctions based on instances of non-compliance for either timeliness or completeness and accuracy. The penalties range as follows:

- **Timeliness:** Failure to comply with timeliness requirements will result in a sanction of up to $10,000 for each program month.
- **Completeness and Accuracy:** If DHS finds an accuracy or completeness error rate exceeding 1% in an annual or semi-annual analysis, penalties range from $4,000 to $100,000.

At the time of this report, DHS reported that none of the CHC-MCOs had incurred penalties; however, DHS has not yet completed activities which could identify instances of non-compliance.

Validation and Feedback to MCOs

DHS engages in specific validation and feedback activities to assist CHC-MCOs in improving future reporting, including:

- DHS posts encounter accuracy, timeliness, and volume reports for each CHC-MCO to ensure CHC-MCOs are aware of their compliance or non-compliance with contractual requirements.

- Bureau of Data and Claims Management (BDCM) generates reports and monitors CHC-MCO activity. The OLTL contract monitoring group initiates corrective action based on BDCM's results when necessary.
- Mercer regularly performs EDV activities to ensure encounter completeness as part of the rate-setting process. For example, Mercer compares each CHC-MCO's financial reporting requirements (FRR) submissions against PROMISe encounter submissions to identify material differences between the two data sources and identify any potential concerns with a particular CHC-MCO's encounter data submission.
- DHS' contract with the CHC-MCO requires an audit of at least 200 sample encounter records to assess completeness and accuracy; however, DHS has not yet completed that audit.

RECOMMENDATION: DHS should consider completing the audit per existing contract terms to more fully comply with CMS recommendations in the following areas:

- Financial Incentives and Penalties
- Validation and Feedback to MCOs

4. Activity 2A: Review CHC-MCO Data Capability

4.1. Overview

Activity 2A Objective: Evaluate the CHC-MCO's ability to submit complete, accurate, and timely encounter data.

Although MCO systems are complex, they are an integral part of the information and data flow between the providers, the Commonwealth, and CMS. Understanding the data exchanges between providers and payers is crucial to the accuracy, timeliness, and completeness of encounter data.

4.2. Approach

Mercer's approach to evaluating CHC-MCOs' data capabilities included four steps, outlined below:

- **Establish evaluation criteria** — Mercer established evaluation criteria to standardize reviews across all three CHC-MCOs.
- **Develop and distribute an RFI** — Mercer developed and distributed an RFI to collect relevant information from the CHC-MCOs.
- **Analyze information submitted by CHC-MCO** — Mercer analyzed the information submitted in response to the RFI.
- **Conduct virtual on-site reviews** — Mercer conducted virtual on-site reviews to confirm our understanding and analysis of the information submitted in response to the RFI, clarify any outstanding questions, and identify any necessary follow-up items.

4.3. Results

OVERALL RESULTS

All CHC-MCOs have sufficient systems, processes, policies, and personnel to successfully monitor encounter data submission and ensure accurate and timely encounter data are available to the State to use for capitation rates, quality measurement, program integrity, and policy development. However, several opportunities for improvement were identified that could strengthen individual CHC-MCO practices and clarify DHS expectations going forward.

The following table summarizes Mercer's assessment of the CHC-MCOs' systems and processes to monitor and ensure accurate and timely encounter data.

Table 4-1: CHC-MCO Systems and Processes

Area of Assessment	AHC	PHW	UPMC
Claims and Encounter Data Systems			
Claims Data Intake	●	●	◒
Security and Business Continuity and Disaster Recovery (BCDR)	●	●	●
Claims and Encounter Processing Systems	●	●	●
Provider Data	●	●	◒
Eligibility Data	●	●	●
Management of Claims and Encounters			
Contract Standards	●	◒	◒
Audit	Indeterminate	Indeterminate	Indeterminate
Encounter Monitoring			
Encounter Data Monitoring Processes	●	●	●

● Meets ◒ Partially Meets ○ Does Not Meet

Below are detailed observations for each area Mercer assessed.

Claims and Encounter Data Systems

Mercer assessed several different aspects of the CHC-MCOs' claims and encounter systems critical to data accuracy and security.

Claims Data Intake

AHC and PHW both met expectations for the criteria Mercer evaluated for claims data intake. UPMC met expectations in all but one category. The table below summarizes Mercer's assessment of each category.

Table 4-2: System Properties

Area of Assessment	AHC	PHW	UPMC
Compliance with Federal Law	●	●	●
Electronic Data Interchange (EDI) Transactions	●	●	●
SNIP Level	●	●	◒

● Meets ◒ Partially Meets ○ Does Not Meet

Compliance with Federal Law

All MCOs reported having their systems, as well as their vendors' systems, in compliance with 42 CFR § 438.242, section 6504(a) of the Affordable Care Act and section 1903(r)(1)(F) of the Social Security Act. More specifically, each CHC-MCO reported sending 837 Professional (837P), 837 Institutional (837I), and NCPDP files to DHS. All three MCOs subcontract for pharmacy, vision, and dental benefits, so some of these files may be generated by vendors and submitted to the MCO as pass-through encounters.

EDI Transactions

All MCOs report compliance with all applicable provisions of HIPAA, including EDI standards for code sets and the 837, 837 Post-Adjudicated Claims Data Reporting (PACDR), 270/271, 276/277, Unsolicited 277, 269, 274, 275, 278, 824, and 835 transactions. The MCOs also shared that they implement EDI transactions in conformance with the appropriate version of the transaction implementation guide, as specified by applicable federal requirements. While the CHC-MCOs may not use all the transaction sets, if business needs arise, they report they can support and operate all the standard EDI transaction sets.

SNIP-Level Edits

SNIP edits apply industry-standard verification of claims at seven levels. All three CHC-MCOs perform SNIP-level edits. While PHW and AHC apply levels 1–4 (integrity testing, requirement testing, balancing and situational testing) and some of level 5 (code set testing), UPMC reported application of only levels 1 and 2. UPMC staff speculated that additional levels are applied using alternative methods; however, they did not provide additional information to verify that speculation. Furthermore, UPMC reported approximately 40% of all claims are pended for additional review.

RECOMMENDATION: UPMC should consider application of additional SNIP edits to increase auto-adjudication rates and reduce manual tasks and interventions with the goal of minimizing errors and paying claims more quickly.

Security and BCDR

Security and BCDR are essential aspects of an organization's overall risk management strategy. It is imperative that the organization employ physical, technical, and administrative system security controls to restrict access, protect data, and identify any threats. **All three CHC-MCOs have appropriate security and BCDR systems in place.**

The following table summarizes each CHC-MCO's industry-standard security certifications, as well as the most recent date on which each CHC-MCO passed BCDR testing.

Table 4-3: System Security and BCDR

Security Component	AHC	PHW	UPMC
Security Certifications	NIST 800-53 R4	ISO 27001, SOC2	HITRUST, SOC2 Type2
BCDR (passed)	October 2022	June 2022	September 2021

Security

Although each MCO uses different certifications, all three organizations implement strong security that complies with nationally recognized standards. PHW and UPMC also listed SOC2 as part of their compliance, indicating additional safety measures.

All three MCOs have policies in place to restrict and monitor access to the premises and information stored in their systems.

BCDR

All three MCOs confirmed that the BCDR plans are in place and tested at least once a year. Appropriate teams are involved with developing test plans and executing the activities. Additionally, all three MCOs confirm they have policies in place to inform all individuals who are part of the core recovery team in the event of a disaster.

Claims and Encounter Processing Systems

System Development

Each MCO attested to having formalized system development life-cycle processes, procedures, controls, and governance frameworks in place for management of its information system and infrastructure, including test environment(s). Each CHC-MCO also described having appropriate processes for any system changes.

Claims Editing

Claims editing is a phase in the claims payment cycle to validate that physician-submitted bills are coded appropriately. These edits can be applied at pre-adjudication and post-adjudication levels. The CHC-MCOs apply required Medicaid National Correct Coding Initiative (NCCI) methodologies and employ various third-party products to validate correct billing and ensure accurate pricing.

The MCOs reported notable differences in the percentages of claims that pended for manual intervention.

Table 4-4: CHC-MCO Pended Claims

CHC-MCO	Percentage of Claims Pended for Intervention
PHW	4%
UPMC	40%
AHC	7%

In particular, as noted in the prior section, UPMC's auto-adjudication process is only able to pay about 60% of the submitted claims, requiring some type of manual intervention for the remaining 40%. UPMC specified that out of these 40%, 26% are processed using automated macros with the remainder being processed by claims analysts.

Claim Form

DHS encourages the use of electronic claims, as it allows for expedited claims processing, tracking of claim status, increased accuracy, fewer denied claims, and decreased overhead costs. The table below summarizes the percentage of claims MCOs report as submitted electronically.

Table 4-5: Percentage of Claims Submitted Electronically

Claim Form	AHC	PHW	UPMC
Hospital	98.0%	98.0%	99.7%
Primary Care Physician	98.0%	96.0%	99.5%
Specialist	98.0%	95.0%	99.6%
Nursing Facility	98.0%	99.4%	98.9%
Home- and Community-Based Services Waiver	98.0%	100.0%	99.9%
Dental	92.9%	83.0%	91.0%
Drug	100.0%	96.5%	99.0%

For most claim forms, CHC-MCOs reported electronic claims percentages from 95% to close to 100%, with the exception of dental claims. PHW and UPMC reported they were undertaking specific initiatives to increase electronic claims use among dental providers.

To reduce paper claims from all providers, staff from each MCO described processes they are using to encourage providers to adopt the use of electronic claims submission. Mercer encouraged all MCOs to continue efforts to motivate providers to submit claims electronically.

Provider Data

MCOs must reconcile their provider data against DHS provider files monthly to ensure:

- All service locations are enrolled and active with Medicaid.
- Provider license information is kept valid and current in PROMISe.

- The Provider Type/Specialty connected to a provider is the same in PROMISe.
- The NPI is the same in PROMISe for each service location.

DHS provides MCOs with PRV414 (weekly PROMISe ID), PRV415 (monthly PROMISe ID) and PRV430 (NPI crosswalk) files. The MCOs use the PRV414 or PRV415 files as well as the PRV430 to reconcile their provider data with that of DHS files and ensure timely and accurate encounter submission.

The following table summarizes the steps each CHC-MCO takes to validate provider data.

Table 4-6: CHC-MCO Provider Data Validation Processes

Validation Process	AHC	PHW	UPMC
PRV414/PRV415 and PRV430 Reconciliation	✓	✓	✓
NPI Reconciliation	✓	✓	✓
Fee Schedule Updates	✓	✓	✓

Below are key observations regarding the CHC-MCOs' provider data reconciliation processes.

- All MCOs attested to using the PRV414 or PRV415 files with the PRV430 on a monthly basis to reconcile their provider database with that of DHS.
- UMPC's NPI application process differs from the process of the other CHC-MCOs. As part of the claims adjudication process, UPMC validates the provider's NPI from the claim against the most recent PRV414 and PRV430 files to confirm PROMISe enrollment. While generating Professional and Institutional encounters, UPMC uses the MPI in the claims adjudication system to link the provider to the PRV430 and then uses the NPI and Taxonomy codes sourced from the PRV430. This process creates the risk that a billing provider's NPI and Taxonomy codes could differ between the outbound encounter and the inbound claim.

RECOMMENDATION: UPMC should consider revising its NPI application process to ensure the billing provider's NPI on the encounter is sourced directly from the claim.

- The CHC-MCOs use the fee schedules to guide provider compensation. However, the CHC-MCOs differed as to the frequency of the fee schedule release. UPMC and AHC reported updating fee schedules monthly. PHW reported loading fee schedules quarterly or as listed in the bulletin posted by the Commonwealth; however, the Commonwealth updates some fee schedules on a more frequent basis (e.g., monthly).

RECOMMENDATION: While not required by DHS, PHW should consider updating its fee schedule monthly to further ensure compliance with the most recent fee schedules.

Eligibility Data

CHC-MCOs must validate their eligibility data to ensure:

- Only eligible members receive services and MCO system(s) match the Pennsylvania eligibility system
- The third party eligibility data is accurate and Medicaid funds are not used when another payer is on file
- Retroactive additions or terminations of members are updated daily to ensure appropriate payment

The MCOs attested to and provided additional details on processing daily eligibility files (834) within 24 hours of receipt, reconciling the file with the member data in their systems as well as submitting the files to their vendors and verifying timely vendor processing of the daily 834 files. Each of the CHC-MCOs have adequate processes in place to validate their eligibility information, as demonstrated in the following table.

Table 4-7: CHC-MCO Eligibility Data Validation Processes

Validation Process	AHC	PHW	UPMC
Daily 834 processing within 24 hours	✓	✓	✓
Enrollment file reconciliation and notification to DHS of any discrepancies within 30 business days	✓	✓	✓
Submission of 834 to the vendor(s)	✓	✓	✓

Management of Claims and Encounters

The quality of encounter data depends on the quality of the claims submitted by the providers, as well as MCOs' capabilities in:

- Editing
- Extracting and preparing the encounter file
- Managing any rejections

The following table details CHC-MCO performance on contractual standards required for claims processing and encounter submissions.

Table 4-8: CHC-MCO Performance on Key Contract Standards

Contract Standard	AHC	PHW	UPMC
Claims Processing			
90% of clean claims within 30 days of receipt	●	●	●
100% of clean claims within 45 days of receipt	●	●	○
100% of all claims within 90 days of receipt	●	●	●
Encounter Submissions			
Medical — On or before the last calendar day of the third month after the adjudication calendar month in which the MCO adjudicated the Claim.	100%	97.1%	97.3%
Pharmacy — Within 30 days following the adjudication date.	100%	Not Tracked[4]	93.8%

● Meets ○ Does Not Meet

UPMC was the only MCO that did not meet the standard for 100% of clean claims processing in 45 days. UPMC reported two separate issues causing the delay of only three claims. One issue was remediated and is not anticipated to continue to occur. The other issue involved a particularly complicated claim that required additional time to adjudicate. There were no additional recommendations identified as necessary to improve UPMC's claim processing, as Mercer agreed that these particular issues were unusual and not representative of the majority of claim activity.

Mercer also assessed each CHC-MCO's ability to process non-standard claims, as detailed in the table below.

[4] PHW stated that during the measurement period timeliness was not tracked. Since changing claims processors, PHW implemented timeliness monitoring and currently is submitting 100% of encounters within contractual requirement.

Table 4-9: CHC-MCO Performance on Non-Standard Claims

Criterion	AHC	PHW	UPMC
Zero Dollar-Paid Claims	●	●	●
Third-Party Lability Claims	●	●	●

● Met ◒ Partially Met ○ Not Met

Below are key observations from Mercer's assessment of each CHC-MCO's ability to process non-standard claims.

- Each of the three MCOs reported appropriate mechanisms for submitting zero dollar-paid claims as encounters. Mercer confirmed each CHC-MCO has zero dollar-paid claims and encounters in the data submitted.
- To ensure the appropriate payment for claims, all three MCOs reported using a variety of methods for obtaining members' additional payer information.
- All three MCOs reported no capitated services, so Mercer did not assess their capabilities in handling these services.

Audit

The complexity of healthcare billing necessitates the development of robust quality assurance and audit techniques. A medical claims audit can be a valuable process to increase claims accuracy and timeliness. It also permits the assessment of compliance with standards, regulations and state guidance, ensures the claims staff has necessary skills to process the claims, and lastly, can be a valuable tool to identify opportunities to recover funds if any improper payments are identified.

Mercer requested information on each CHC-MCO's audit practices. The information they reported varied, as summarized in the table below.

Table 4-10: CHC-MCO Audit Samples

Metric	AHC	PHW	UPMC
Claims Audited (Q3 and Q4)	109,114	495	19,956
Total Claims Processed	8,814,082	Not submitted	584,492
Percentage Audited	1.1%	Cannot be calculated	3.4%

Below are key observations regarding the audit information each CHC-MCO provided.

- PHW did not provide the information Mercer requested and instead reiterated the use of a standardized sample generator to generate the number of selections. PHW limited its response to stating the financial and payment accuracy for the last two quarters of 2020 were greater than 99%. Although these metrics appear to be high, it is worth noting that

the claims audit was very limited and cannot be compared to the other two MCOs. However, this requirement was deemed met due to an absence of neither contractual nor regulatory requirements.

- The number of claims processed and claims audited varied significantly between UPMC and AHC. The 2020 membership for these two CHC-MCOs is comparable, so such a discrepancy may be indicative of an inaccurate submission or the inclusion of non-CHC claims. Therefore, a meaningful comparison of the two plans is not possible.
- While it is difficult to draw conclusions based on the reported data, AHC described their audit processes, including daily audits of at least 2% of each claims processor's output and 1% of all auto-adjudicated claims. Additionally, AHC noted these audits can be supplemented by targeted audits as requested by claims management.
- In addition to production audits, UPMC performs ad hoc and focused audits relying on random and focused sampling methods. UPMC also described processes to audit vendor claims, which included monitoring to ensure implementation of necessary adjustments.

RECOMMENDATION: Given the different audit approaches, CHC-MCOs may benefit from more direction from DHS on audit techniques and sample sizes to ensure their performance and audit findings are consistent and meet expectations.

Encounter Monitoring

In the EDV protocol, CMS recognizes that multiple entities must collaborate to improve the quality of encounter data. Providers must understand the policies and requirements of correct billing. MCOs must be able to accept provider claims, pay claims accurately, and work with the providers to promote electronic submission. Finally, the Commonwealth and CMS must develop robust systems that are ready to accept correct data.

As a key contributor to the collaboration, CHC-MCOs have tremendous responsibility to monitor the quality of the claims and encounter data from the initial steps of accepting the claims into their systems to correcting and resubmitting any rejected records through PROMISe. The table below details fundamental steps the CHC-MCOs undertake to support effective encounter monitoring.

Table 4-11: CHC-MCO Encounter Monitoring Steps

Encounter Monitoring Step	AHC	PHW	UPMC
Encounter Files Creation	✓	✓	✓
Response Management	✓	✓	✓
Encounter Errors Resolution	✓	✓	✓

Encounter Monitoring Step	AHC	PHW	UPMC
Encounter Vendor Oversight	✓	✓	✓
Financial Reconciliation	✓	✓	✓

Encounter Data Monitoring Processes

Below are several key observations about the processes each CHC-MCO employs to support effective encounter data monitoring.

- All MCOs submitted detailed responses and included encounter submission data flows as well as descriptions of their encounter corrections and resubmission process. Although the CHC-MCOs use different systems to generate the encounter data file, all follow very specific processes to ensure accurate encounter data.
- When a CHC-MCO submits a file, PROMISe can accept the file, reject the file or reject individual records. The CHC-MCOs employ robust processes to correct and resubmit rejected encounters, which include:
  - Operational reports and dashboards with information on each claim number and reject code/description received in the response file.
  - Interdepartmental meetings and encounter workgroups to address recurrent issues and improve processes in the flow of encounters to the PROMISe system.

5. Activity 2B: Financial Audit Activity

5.1. Objective

Activity 2B Objective: Assess the accuracy, completeness, and truthfulness of contractually required financial schedules used in the capitation rate-setting process.

Mercer focused this audit on financial data used by Mercer actuaries as a critical part of the CY 2022 capitation rate development process. Specifically, the audit is designed to ensure the data are appropriate for rate setting and are consistent with the encounter data reported through PROMISe.

5.2. Approach

The CHC-MCO financial schedules are subject to an examination by the CHC-MCO Independent Public Accountant (IPA). The IPA's attestations for financial schedules include language that:

- The examinations are conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and the standards applicable to attestation engagements contained in Governmental Auditing Standards, issued by the Comptroller General of the United States.
- In the IPAs' opinion, the financial schedules for the periods reviewed are presented in accordance with accounting principles prescribed by the Commonwealth of Pennsylvania Department of Human Services (DHS).

The IPA examination includes the following contractually required financial schedules utilized in rate setting.

- Report #4 — Lag Reports
- Report #5 — Income Statements (this Report includes Report #1 — member month data)
- Report #14 — In-Lieu of Services Summary Report
- Report #15 — Expanded/Value-Added Summary Report
- Report #42 — Medical Loss Ratio Reporting

In CY 2020, there were no findings identified by the IPA with the CHC-MCO financial submissions. Given the results of the IPA examinations of the financial schedules utilized in setting capitation rates, Mercer determined these reports did not require additional review during this audit process. That said, Mercer determined that a comparison of encounters to Report #4 would provide additional assurance that financial statement amounts agree to encounter totals. We selected Report #4 because it provides detail on claims paid by the CHC-MCOs for CY 2020 with a run-out period that can be tied to specific encounters approved by PROMISe with the same dates of service.

The sections below provide the results of the Report #4 to encounter comparison for each of the CHC-MCOs.

5.3. Results

OVERALL RESULTS

Statewide across all CHC-MCOs, submitted encounters support 98.3% of reported financial statement data.

Mercer's analysis shows individual CHC-MCO results are consistent with the statewide average, ranging from 97.6% (UPMC) to 98.9% (AHC). The table below summarizes each CHC-MCO's overall results.

Table 5-1

Report #4: Lag Tables to Accepted PROMISe Encounters				
CHC-MCO	Financial Data[5]	Encounter Data[6]	Difference[7]	Percentage Complete[8]
AHC	$4,080,439,874	$4,036,550,770	$43,889,104	98.9%
PHW	$2,226,493,402	$2,178,717,379	$47,776,023	97.9%
UPMC	$2,320,383,417	$2,264,485,555	$55,897,862	97.6%
Statewide All CHC-MCOs	$8,627,316,693	$8,479,753,705	$147,562,989	98.3%

Note: Totals may not add due to rounding differences.

In addition to comparing Report #4 financial data to PROMISe encounter data statewide for each CHC-MCO, Mercer developed individual CHC-MCO comparisons for each zone to determine whether results were consistent across zones. Each CHC-MCO showed consistent results across zones, as demonstrated in the table below.

Table 5-2

Zone	AHC	PHW	UPMC
Southwest	99.0%	98.4%	97.9%
Southeast	99.0%	97.4%	97.9%
Lehigh/Capital	98.8%	98.1%	97.8%
Northeast	98.7%	98.2%	95.6%

[5] Financial Data reflects CY 2020 data from Q4 2021 CHC-MCO financial submissions, utilizing Month of Service/Month of Payment Lag Triangle and the Subcapitation Payment detail from Report #4 and both In-Lieu of Services and Expanded/Value-Added Services from Report #5. Other Report #4 adjustments reported below the Lag Triangles (e.g. Nursing Facility Access to Care payments, Rx rebates, Pharmacy Benefit Manager adjustment, etc.) are not reflected for comparison purposes.

[6] Encounter Data reflects CHC PROMISe encounter data, limited to services for CY 2020 time period (January 2020 through December 2020) with payment runout through December 2021.

[7] Difference equals financial data greater than encounter data (financial data less encounter data).

[8] Percentage complete represents the percentage of financial data that is substantiated by accepted encounter data (encounter data divided by financial data).

Zone	AHC	PHW	UPMC
Northwest	98.9%	98.3%	97.5%
Statewide	**98.9%**	**97.9%**	**97.6%**

6. Activity 3: Analyze Electronic Encounter Data

6.1. Overview

Activity 3 Objective: Assess electronic encounter Data Completeness and Data Accuracy, with a focus on data elements affecting capitation rate development.

As part of Activity 3, the data analytics compare the claims data extracts submitted by the CHC-MCOs as part of this audit to the PROMISe encounter data extract. Consistent with other review activities, Mercer used the CMS protocol as a framework to complete the data analytics.

6.2. Approach

To accomplish the objective of Activity 3, Mercer conducted a series of analyses of CY 2020 encounter data. Mercer established a data analytics approach based on information learned through Activities 1 and 2, discussions with DHS, and our nationwide Medicaid encounter data experience.

Data Sources

Mercer established two CY 2020 encounter data sources for Activity 3.

- **PROMISe data** — Mercer used the CY 2020 encounter data extract received regularly from DHS.
- **CHC-MCO data** — Mercer developed a data request for the CHC-MCOs to provide a CY 2020 claims data extract from each of their systems. Mercer requested claims data fields consistent with encounter fields CHC-MCOs submit to DHS' PROMISe system.

CHC-MCOs are required to submit encounters to DHS' PROMISe system for all paid Medicaid services and many denied Medicaid services for all enrolled members. Comparing data from the PROMISe system and the CHC-MCO claims processing systems represents the best method for determining whether Pennsylvania's encounters are corroborated by and faithfully represent the information contained in the CHC-MCOs' in-house claims processing systems.

DHS PROMISe Encounter Data

Mercer intakes, loads, and processes weekly PROMISe encounter extract files for use in capitation rate development. To conduct the data analytics for this audit, Mercer utilized this PROMISe data source for CY 2020 dates of service and PROMISe submission dates through January 7, 2022 to align with the CHC-MCO data request.

CHC-MCO Claim Data Extracts

To obtain claim data directly from the CHC-MCOs, Mercer developed a detailed data request for a single file, including field names, descriptions, and format parameters. In this data request, Mercer asked each CHC-MCO to submit claims data with dates of service from January 1, 2020 through December 31, 2020 (CY 2020). The request specified that CHC-MCOs were to send Institutional, Professional, and Pharmacy data based on the status of the claim as of January 7, 2022.

Once Mercer received claims data extract files from the CHC-MCOs, we performed an initial, high-level data review to confirm the CHC-MCOs provided the requested information and that the information appeared reasonable. The preliminary file review included the following checks:

- Review of data submission files, fields, and control totals.
- Assessment of compliance with data request specifications.
- Review of field population and validity of provided values.

As a result of the high-level reviews, Mercer identified several initial concerns with the CHC-MCO-submitted files. After Mercer shared these concerns with DHS, DHS followed-up with each CHC-MCO to obtain clarification on the submitted data and allow data resubmissions. AHC and PHW, but not UPMC, chose to resubmit their claims data extract.

Data Modifications

Prior to performing the data analytics described in this section, Mercer made several modifications to better align the information between the data sources. These modifications included:

- Any Institutional or Professional records with a value in the national drug code (NDC) field were reassigned to the Pharmacy claim form (regardless of if the records were originally submitted on an 837I or 837P claim form). This update was applied to the CHC-MCO submitted claims data to align with how CHC-MCOs are required to submit physician-administered drug encounters to PROMISe.
- Recipients not enrolled in CHC on the date of service were removed from both data sets.
- Denied claims apart from those denied for DHS-permitted reasons were removed from the CHC-MCO claims extract if the Header Amount Paid was $0.00.
- Dates of service outside of CY 2020 were removed using the Header First Date of Service (HFDOS) field.

Data Source Limitations

Several limitations regarding the data used in this analysis, the resulting findings, and the extent to which larger conclusions can be drawn should be noted. Specifically:

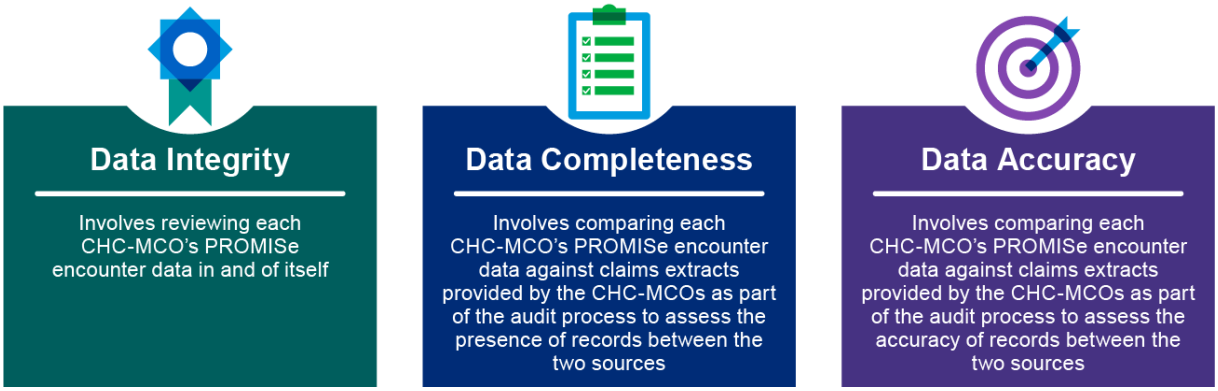
- Given the volume and complexity of the data sources and procedures in this audit, there are limitations on the depths to which its procedures can independently examine reported information.

- While Mercer prepared a detailed data request to guide their response, it is unlikely that all three CHC-MCOs accurately pulled all and only the claims data requested. All three CHC-MCOs were approached with questions/concerns regarding their initial submission, and two of three chose to resubmit. Mercer proceeded with some CHC-MCO claims extracts despite known issues.
- The scope of this audit does not include a comparison of the PROMISe system to each CHC-MCO's claims system. As such, any findings, observations, or recommendations represent the results of comparing two snapshots of underlying data sources and could be the result of issues in the snapshots rather than the systems themselves.

6.3. Data Analytics Approach

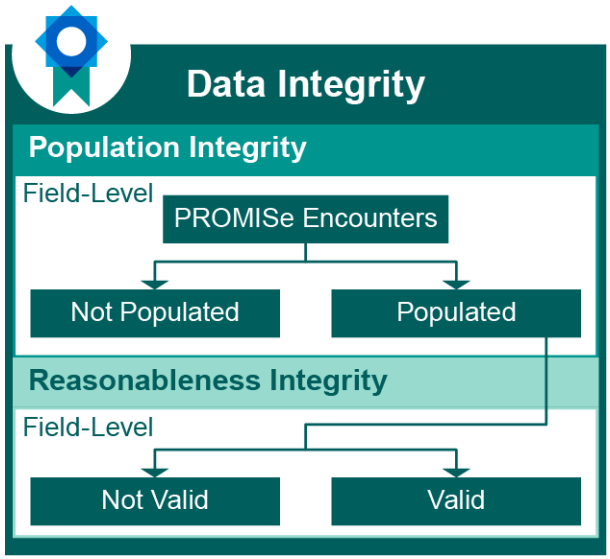
Once Mercer obtained usable CHC-MCO claim data extract files and extracted PROMISe encounter data files for the same time period, we performed data analytics on the PROMISe encounter data to assess Data Integrity, Data Completeness, and Data Accuracy. We focused the data analytics on select data fields that inform or influence capitation rate development and performed these analyses separately for the following claim forms: Institutional (including PROMISe Inpatient and Outpatient), Professional, and Pharmacy.

We organized analytics performed during this activity into three categories based on recommendations included in CMS' EDV Protocol #5. These included the following:



Data Integrity

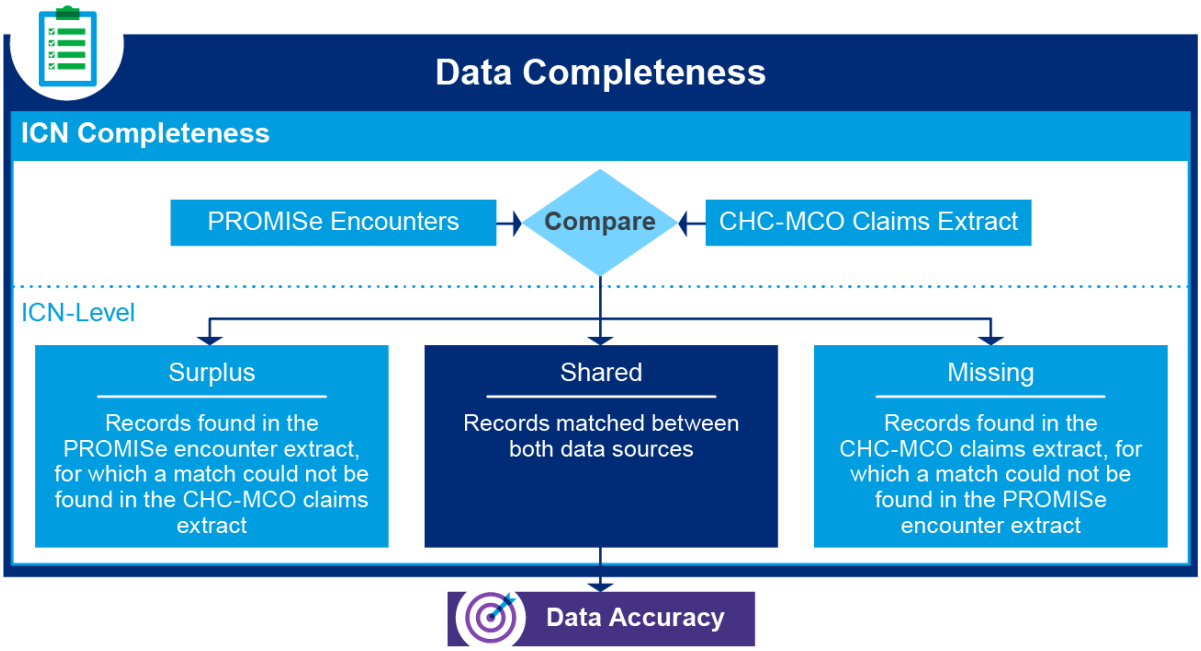
The Data Integrity analyses focus exclusively on the PROMISe encounter data for each CHC-MCO and are further organized into two sub-analyses: Population Integrity and Reasonableness Integrity. The comparisons we performed during each sub-analysis included each claim form (Institutional, Professional, and Pharmacy).



- **Population Integrity:** This sub-analysis focuses on each CHC-MCO's PROMISe encounter records to measure the rate at which certain fields are populated.
- **Reasonableness Integrity:** This sub-analysis focuses on populated fields only for each CHC-MCO's PROMISe encounter records, evaluating, where possible, whether the values populated are reasonable and conform to acceptable field values.

Data Completeness

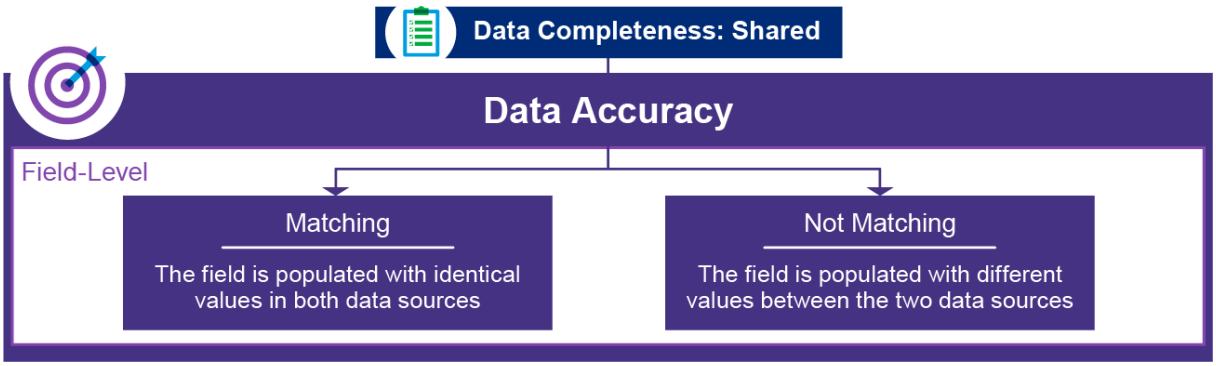
This analysis represents the first step during which we compare CHC-MCO PROMISe encounter data against the CHC-MCO claims extracts provided as part of the audit and focuses on determining whether encounter records present in one source can be matched to records found in the other. The comparisons we performed included each claim form (Institutional, Professional, and Pharmacy).



In the analysis of Internal Control Number (ICN) Completeness, we compare the PROMISe encounter extract against CHC-MCO claims extracts provided as part of the audit to organize all services at the PROMISe ICN and PROMISe Number Detail-level into three categories: shared, missing, and surplus, as explained in the graphic above.

Data Accuracy

In the Data Completeness analysis we evaluate whether encounters can be found in both data sources. We build upon the Data Completeness step in the Data Accuracy analysis by determining whether shared records are populated *with matching values*. Beginning with the universe of shared records from the Data Completeness step above, we organize line-level data into the two categories below. The comparisons we performed during each sub-analysis included each claim form (Institutional, Professional, and Pharmacy).



6.4. Data Analytics Results

OVERALL RESULTS

For each of the major categories of analyses Mercer conducted, we found the following:

- Overall, the program displays an expected degree of encounter data quality given that CY 2020 represents the first year of statewide program implementation.
- Most fields in the CHC encounter data which are expected to be populated are populated in a high number of instances. When fields are able to be assessed for reasonability, they generally contain reasonable values.
- An acceptable degree of matching records was observed for Professional and Pharmacy claim forms for all CHC-MCOs and for Institutional claim forms for two of three CHC-MCOs.
- The accuracy of CHC encounter data could be improved for all CHC-MCOs.
- We discovered several issues with UPMC's Institutional data that DHS should further investigate to understand the scope of the issue. This compromised the audit's ability to produce meaningful conclusions for UPMC Nursing Facility records, a major source of program cost.

Following the same order as explained above, this section presents the results of the data analytics Mercer performed. Each subsection presents results by claim form, including Professional, Pharmacy, and Institutional results.

Data Integrity Results

Mercer examined all PROMISe encounter fields for Population Integrity to measure the rate at which fields are populated. Certain fields for certain claim forms may be appropriately unpopulated in some cases, while others should always contain a value.

The graphs and narratives included in this section summarize the PROMISe Data Integrity results by claim form, for both the Population Integrity and Reasonableness Integrity sub-analyses.

- **The Population Integrity** section highlights population rates only for fields that should always be populated.
- **The Reasonableness Integrity** analysis focuses only on those fields for which a known set of acceptable values exists and highlights the rate at which fields are populated with these acceptable values.

A complete list of fields included in both the Population Integrity and Reasonableness Integrity analyses for each claim form is in Appendix A.

For each of the Population Integrity and Reasonableness Integrity analyses, we present results first at an aggregate level for all claims forms. We then further break down the results by specific claims forms: Professional, Pharmacy, and Institutional. For the Institutional analyses, we also provide further analyses based on Inpatient and Outpatient claims sub-types. Graphics have been included in most cases to illustrate meaningful observations, though in some cases these have been omitted when results are simply described.

Population Integrity

All Claim Forms

Across all claim forms, 74 of the fields Mercer examined should be populated in all circumstances.[9] The following graphs illustrate which of those fields are populated at rates in one of three frequency ranges:

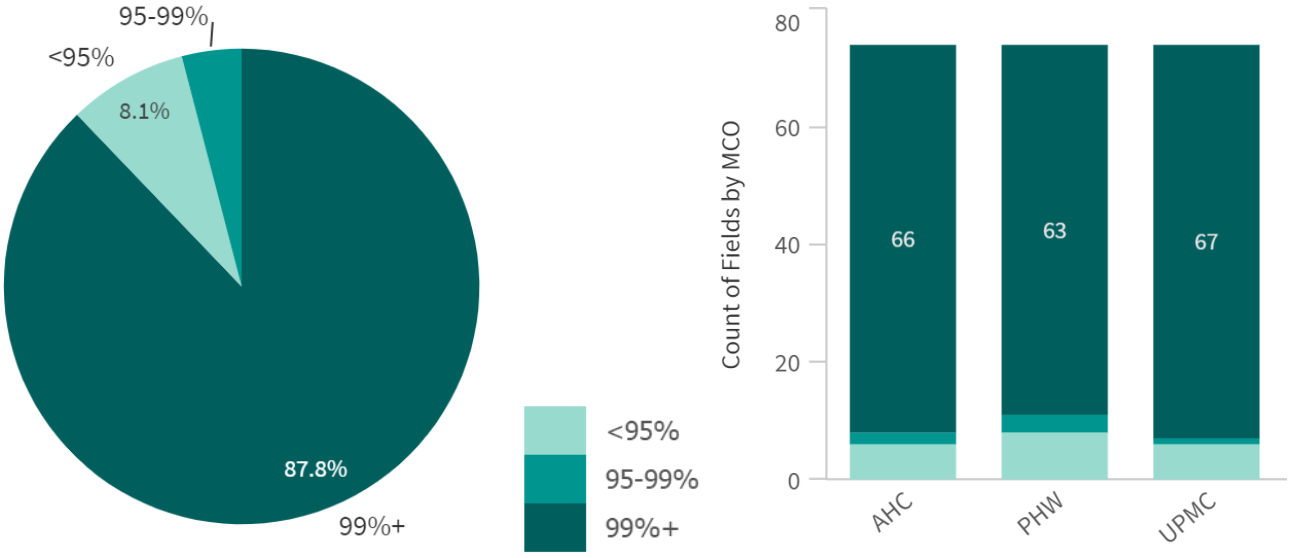
- The field was populated at a rate greater than 99% **(99%+)**.

[9] Some of these fields (e.g., Recipient ID) are counted once for each type of encounter (Institutional, Professional, and Pharmacy). The total of 74 fields may therefore count a given field more than once if it appears in more than one claim form.

- The field was populated at a rate between 95% and 99% **(95%–99%)**.
- The field was populated at a rate less than 95% **(<95%)**.

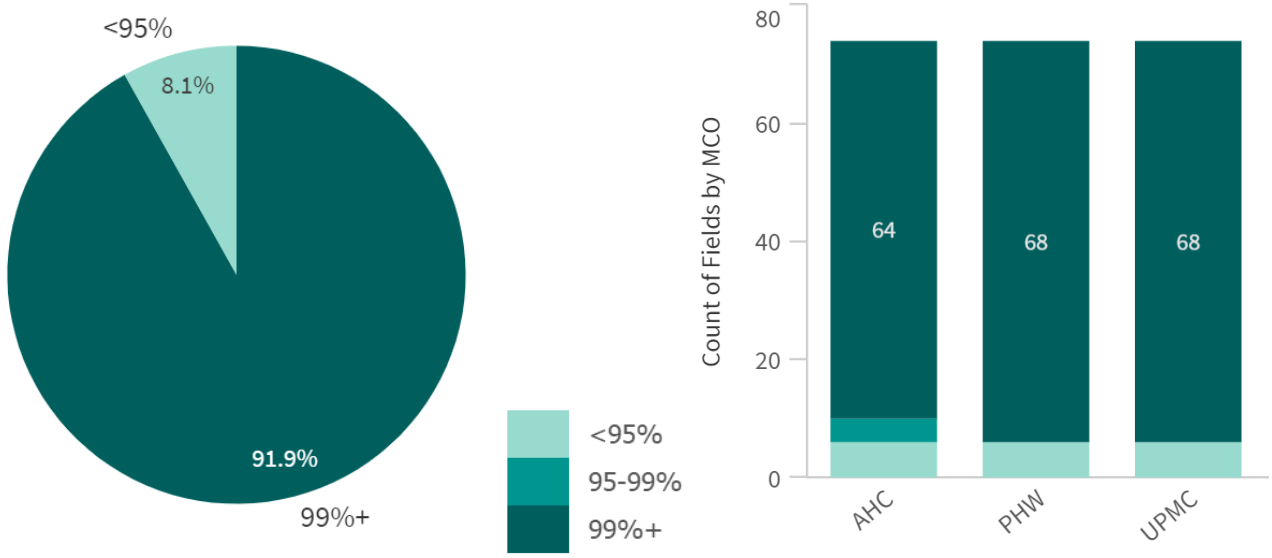
The pie chart on the left displays the results for all 74 fields weighted across all CHC-MCOs, while the bar graph on the right illustrates each individual CHC-MCO's results across the 74 fields.

Graph: Population Integrity — All Claim Forms by Record Count



Mercer calculated the integrity measures weighted in two ways: on record count and on paid amounts. In the case of record count, results weight each encounter record equally. When measured by paid amount, results reflect the relative dollar weight or value. We have included both graphs here, but in future analyses, we provide both graphs only in cases where they are useful to illustrate a meaningful difference.

Graph: Population Integrity — All Claim Forms by Paid Amount



Key Observations Regarding Population Integrity — All Claim Forms

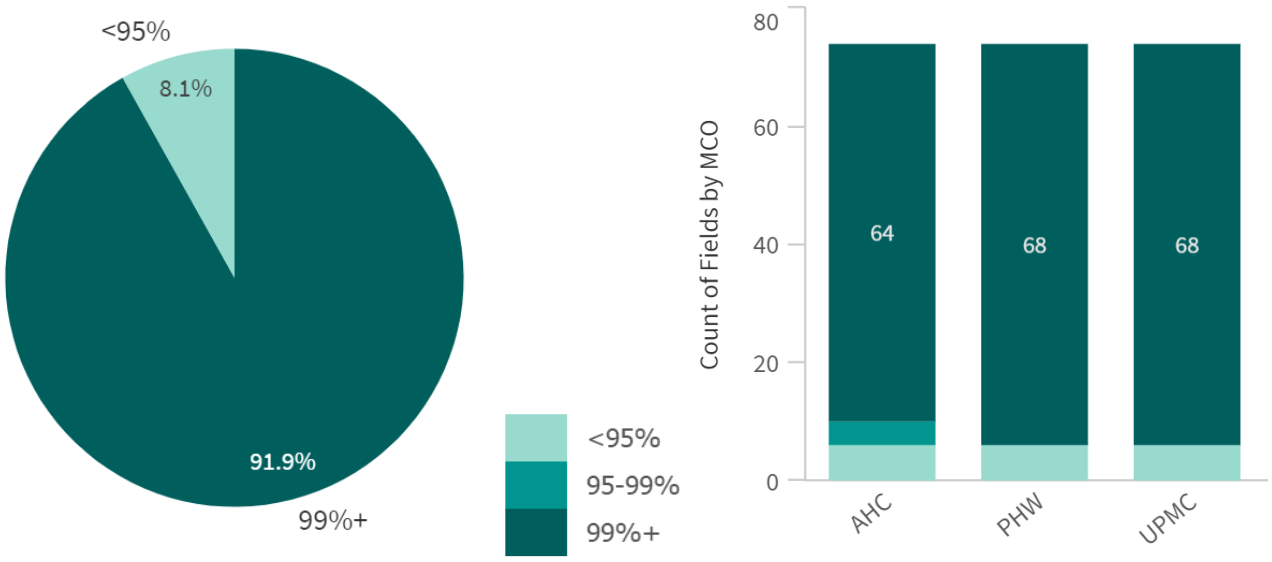
- As noted earlier, we expect these 74 fields to be populated 100% of time. On a statewide basis, 88% of these fields were populated at a rate of 99% or better, as measured by record count. When weighted by paid amounts, the proportion of fields in the 99%+ category increases to 92%, suggesting larger value claims tend to have higher population rates.
- On an individual level, the Population Integrity results were fairly consistent across CHC-MCOs. All CHC-MCOs showed a 99%+ population rate for more than 85% of fields, whether measured by record count or paid amount.

Population Integrity

Professional

As mentioned above and across all claim forms, 74 fields are expected to be populated in all cases, and 92% of these fields are populated for 99%+ of encounters (by paid amount). Eighteen of these fields are present on Professional encounters, and these results display population rates for these specific fields for the Professional claim form only.

Graph: Population Integrity — Professional Paid Amount



Key Observations Regarding Population Integrity — Professional Claim Forms

- Across all CHC-MCOs (by paid amount), approximately 83% of the 18 fields were populated at a rate of 99% or better. Eighty-three percent is less than the aggregate result of 92% across all claim forms, indicating that the Professional Population Integrity results are lower than other claim forms.
- On an individual CHC-MCO level, the Population Integrity results for the Professional claim form were consistent.

All three CHC-MCOs achieved 99%+ Population Integrity rates in fields key to capitation rate development, such as:

- Approved/Rejected Indicator, Capitation FFS Indicator, CPT/HCPCS Procedure Code, Detail Amount Paid, Detail Copay Amount, DFDOS, Diagnosis 1, Header Amount Billed, Header Amount Paid, Header Medicare Paid, HFDOS, MCO Code, MCO Paid Date, POS, and Recipient ID Number.[10]

Each CHC-MCO's results showed the same three fields were populated less than 95% of the time. Those fields are:

- Billing Provider NPI.
- Header Copay Amount.
- Performing Provider NPI.

[10] Fee-for-service (FFS), Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS), Detail First Date of Service (DFDOS), and Place of Service (POS).

Population Integrity

Pharmacy

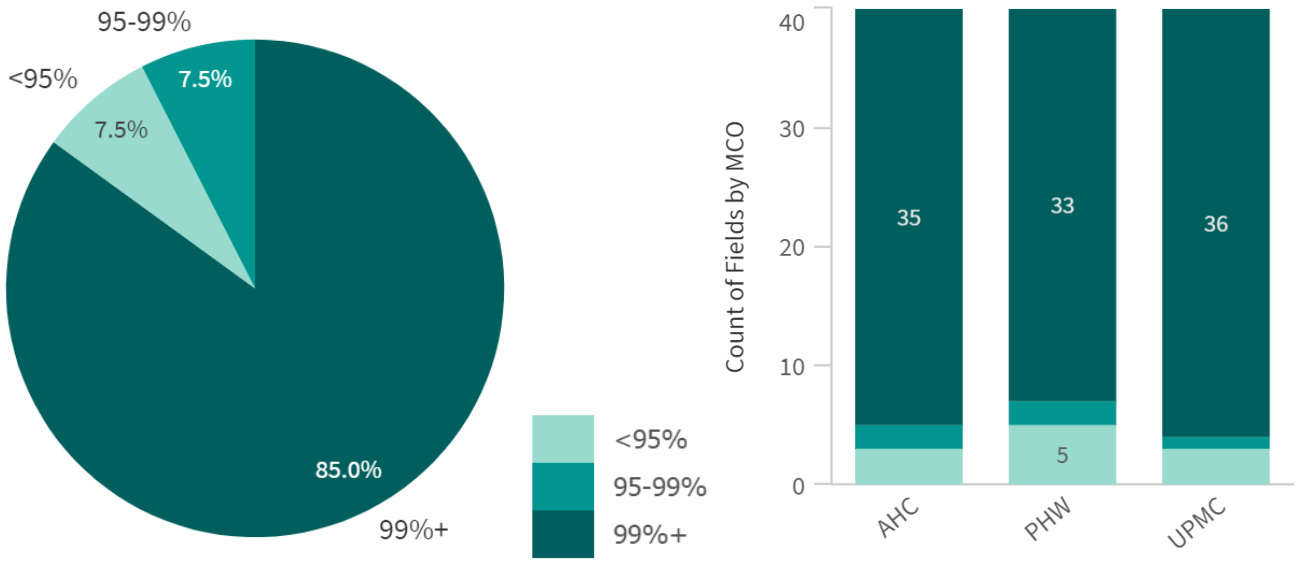
Of the 74 fields expected to be populated in all cases, 16 of these fields are present on Pharmacy encounters. When measured by both record count and by paid amounts, statewide and individual CHC-MCO results showed population rates of 99%+ for all fields, including all fields critical to capitation rate development. The population rates for Pharmacy encounters are the highest among the three claim forms and above the aggregate 92% observed across all claim forms.

Population Integrity

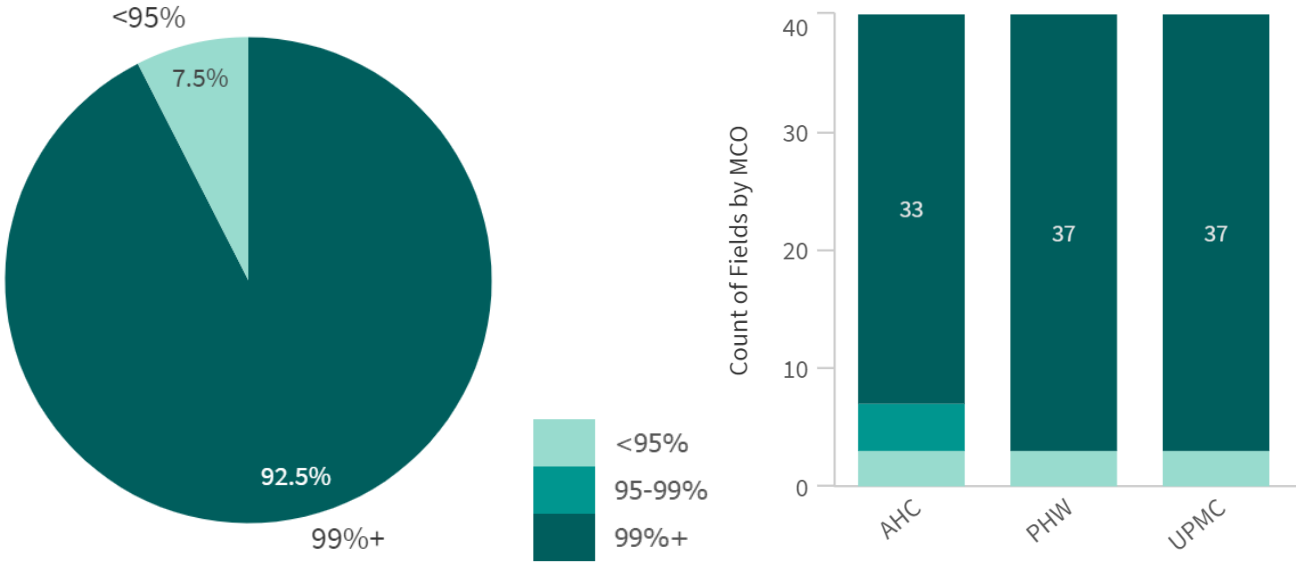
Institutional

Forty of the 74 fields expected to be populated in all cases are present on Institutional encounters. For Institutional, some fields were reviewed once for Inpatient data and once for Outpatient data. Other fields were only reviewed once, for either Inpatient or Outpatient. Below we provide the population rates for these specific fields on the Institutional claim form only.

Graph: Population Integrity — Institutional Record Count



Graph: Population Integrity — Institutional Paid Amount



Key Observations Regarding Population Integrity — Institutional Claim Forms

- Across all CHC-MCOs, 85% of the 40 fields were populated at a rate of 99% or better, based on record count. When weighted by paid amount, the results increase to almost 93%. These results are consistent with those observed in aggregate across all claim forms and suggest higher dollar claims tend to have higher population rates.
- On an individual CHC-MCO level, the Population Integrity results were generally consistent across all three.
- The population rate for all three CHC-MCOs ranged between 95% and 99% for the Outpatient CPT/HCPCS Procedure Code, which is a field key to capitation rate development.

All three CHC-MCOs achieved 99%+ Population Integrity rates for both Inpatient and Outpatient (where applicable) in fields key to capitation rate development, including:

- Admission Date, Admission Source, Approved/Rejected Indicator, Billing Provider NPI, Covered Days, Detail Amount Paid, Detail Copay Amount, DFDOS, Diagnosis 1, Header Amount Billed, Header Amount Paid, Header Copay Amount, Header Medicare Paid, HFDOS, MCO Code, MCO Paid Date, Recipient ID Number, Revenue Code, Type of Admission, and Type of Bill.

Each CHC-MCO's results showed three of the same Inpatient fields were populated less than 95% of the time. Those fields are:

- MCO DRG[11].
- MCO DRG Type.
- Present on Admission 1.

[11] Diagnosis related group (DRG).

Reasonableness Integrity

All Claim Forms

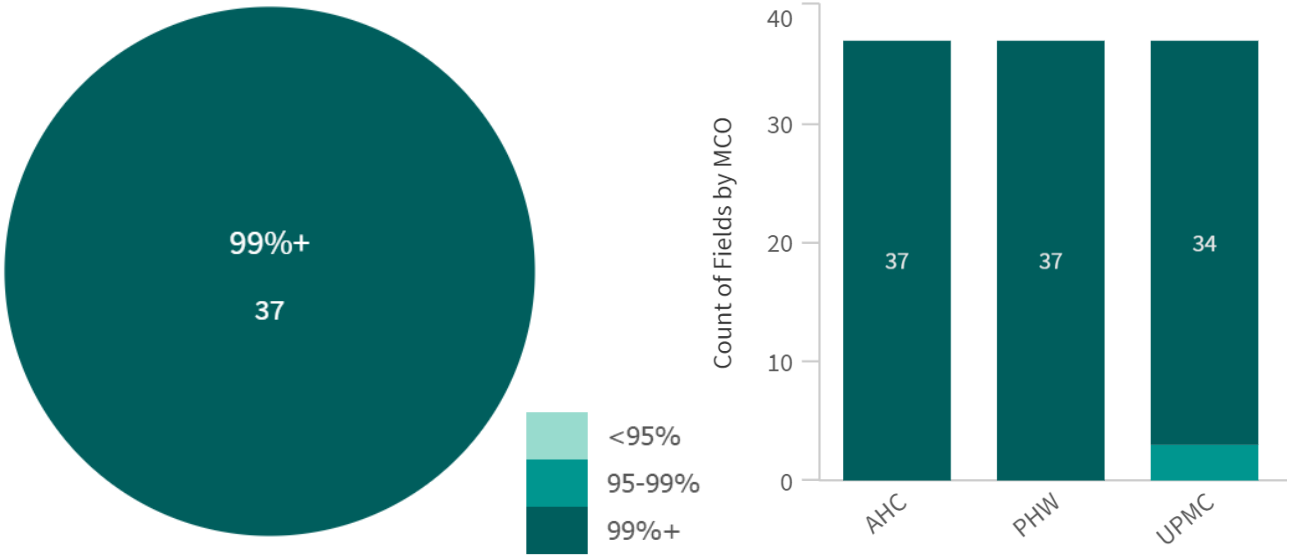
As described earlier, the Reasonableness Integrity analysis focuses only on those fields for which a known set of acceptable values exists. Unlike Population Integrity, Reasonableness Integrity includes fields for which we do not expect 100% population rates, as long as those fields have a defined set of reasonable values.

Across all claim forms, we identified 37 fields that can be evaluated for Reasonableness Integrity. The following graphs illustrate which of those fields are populated with reasonable values at rates in one of three frequency ranges:

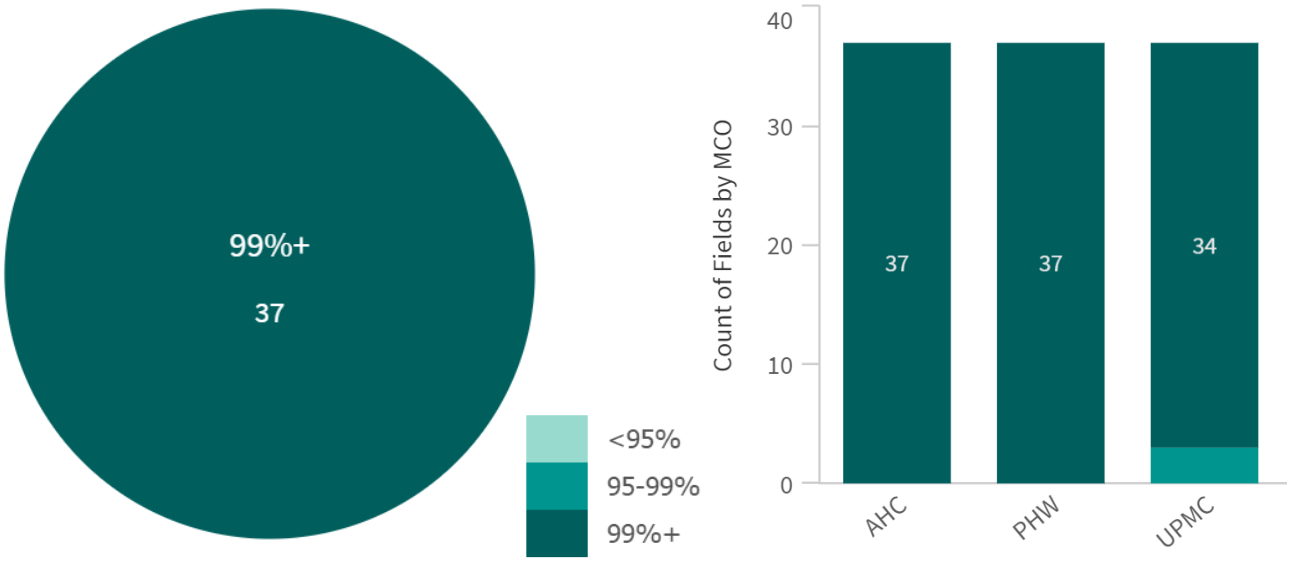
- The value appears reasonable at a rate of greater than 99% **(99%+).**
- The value appears reasonable at a rate between 95% and 99% **(95%–99%).**
- The value appears reasonable at a rate less than 95% **(<95%).**

The pie chart on the left displays the results for all 37 fields weighted across all CHC-MCOs, while the bar graph on the left illustrates each individual CHC-MCO's results across the 37 fields.

Graph: Reasonableness Integrity — All Claim Forms Record Count



Graph: Reasonableness Integrity — All Claim Forms Paid Amount



Key Observations Regarding Reasonableness Integrity — All Claim Forms

- On a statewide basis, the reasonableness rate was 99%+ for all 37 fields, as measured by both record count and paid amounts.
- UPMC was the only CHC-MCO with results below 99%. The fields in this category were Modifiers 2, 3, and 4. Mercer found these three modifiers to be unpopulated on all UPMC Institutional encounters.
- Results by claim form were consistent with the aggregate results illustrated above.
  - All 15 fields for the Professional and Pharmacy claim forms had reasonableness rates of 99%+ statewide and for each CHC-MCO individually.
  - Measured on a statewide basis, all 22 fields measured for the Institutional claim form had results above 99%. All 22 fields for AHC and PHW were above 99%, while UPMC had 19 of 22 fields above 99%.
- All fields key to capitation rate development had reasonableness rates exceeding 99%.

Because results for the Reasonableness Integrity analysis were so consistent, we have not included illustrations of the results by claim form.

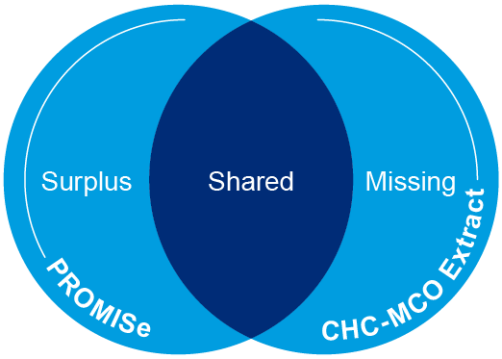
Data Completeness Results

As explained previously, the Data Completeness analysis focuses on determining whether encounter records present in the PROMISe encounter extract can be matched to records found in the CHC-MCO claims extract provided by the CHC-MCO as part of the audit. We performed this analysis in aggregate and for each claim form (Institutional, Professional, and Pharmacy) weighted by both record count and paid amount.

As part of the analysis, we organized all encounter records into three categories:

- **Shared:** records matched between both data sources
- **Missing:** records found in the CHC-MCO claims extract, for which a match could not be found in the PROMISe encounter data extract (i.e., missing in PROMISe extract)
- **Surplus:** records found in the PROMISe encounter data extract, for which a match could not be found in the CHC-MCO claims extract

The following graphic illustrates the relationship among these categories.



The ICN Completeness graphs in this section display the missing, surplus, and shared records as a percentage of the unique PROMISe records. The pie chart on the left displays the results for weighted across all CHC-MCOs, while the bar graph on the right illustrates each individual CHC-MCO's results. For missing or surplus records, a lower rate indicates greater alignment between the two data sources. For shared records, a higher rate indicates greater alignment.

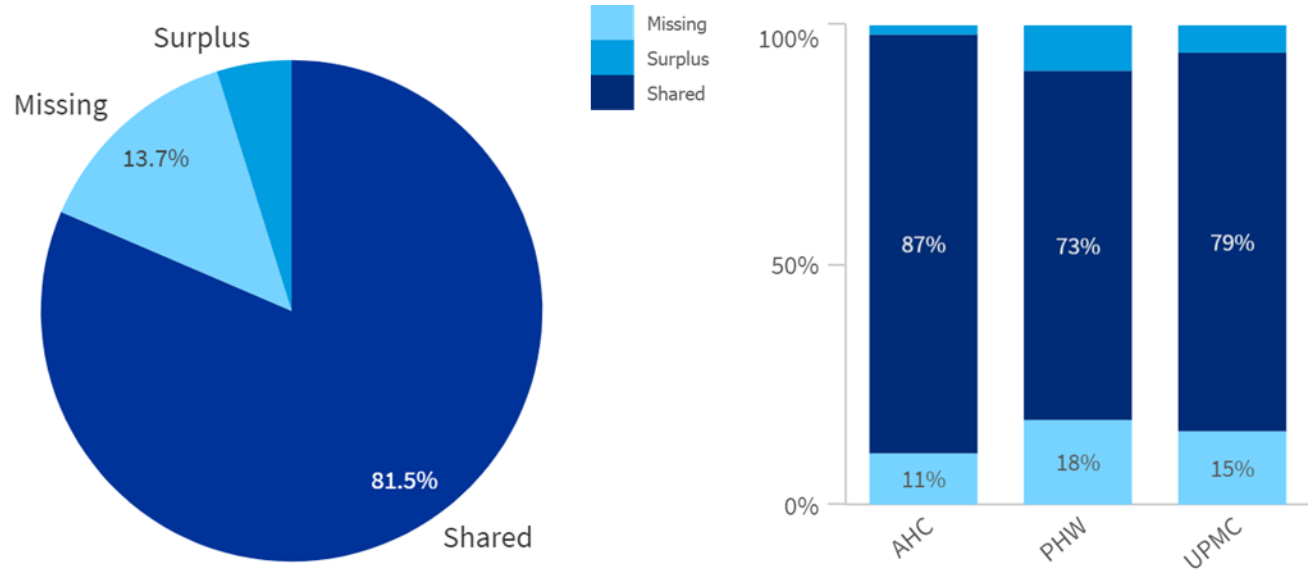
ICN Completeness

All Claim Forms

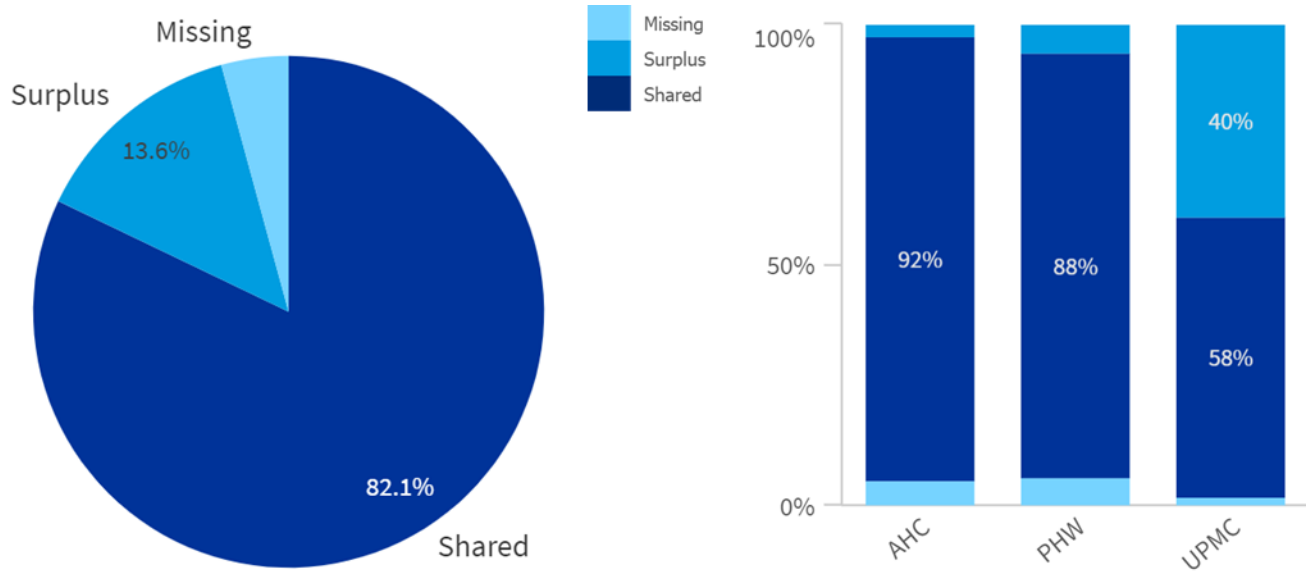
As discussed earlier, we measure ICN-level Data Completeness in aggregate (across all claims forms) and for each claim form (Professional, Pharmacy, and Institutional), as well as by record count and weighted by paid amount.

Below we present results in aggregate. Following this section, we provide the results by claim form to illustrate some of the specific influences each claim form has on overall results.

Graph: ICN Completeness — All Claim Forms Record Count



Graph: ICN Completeness — All Claim Forms Paid Amount



Key Observations Regarding ICN Completeness — All Claim Forms

- As measured by record count, 81.5% of encounters were identified as shared across all claim forms, indicating that these encounters are found in both data sets. However, the CHC-MCOs showed some variation in their individual results, ranging from 73% (PHW) to 87% (AHC).

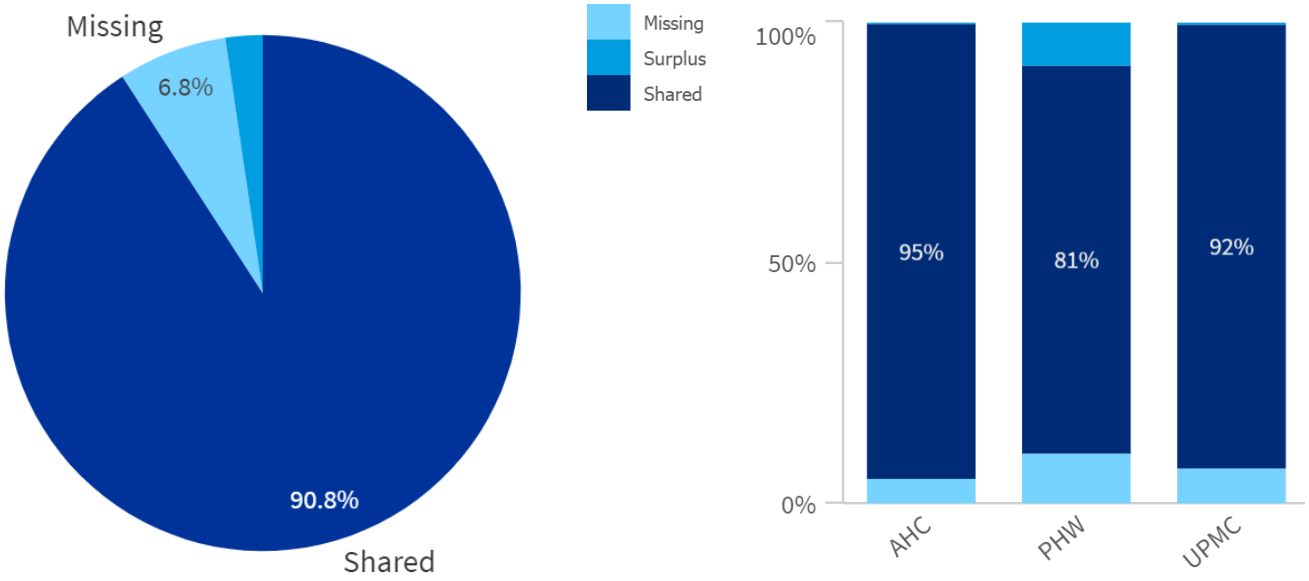
- While statewide shared results were similar (82%) when measured by paid amount, individual CHC-MCO results were notably different. In particular, UPMC's shared percentage is noticeably lower when measured by paid amount: 58%, compared to 79% by record count. UPMC's surplus percentage (the percentage of records present in the PROMISe data but not in the UPMC extract) increased to 40% from 6%. This difference seems to indicate the surplus encounters are, on average, of notably higher value than those in the shared or missing categories. Mercer observed issues with UPMC's Institutional claims data (explained further below) that may contribute to this observation.
- As measured by record count, the majority of non-shared records fell into the missing category. This indicates that the number of MCO-provided claim records that could not be found in PROMISe exceed the number of PROMISe records that could not be found in the MCO-provided claim extracts.
- When measured by both record count and paid amount, AHC had the lowest proportion of both missing and surplus records, indicating the strongest alignment between AHC's claim extract and PROMISe encounter records.

ICN Completeness

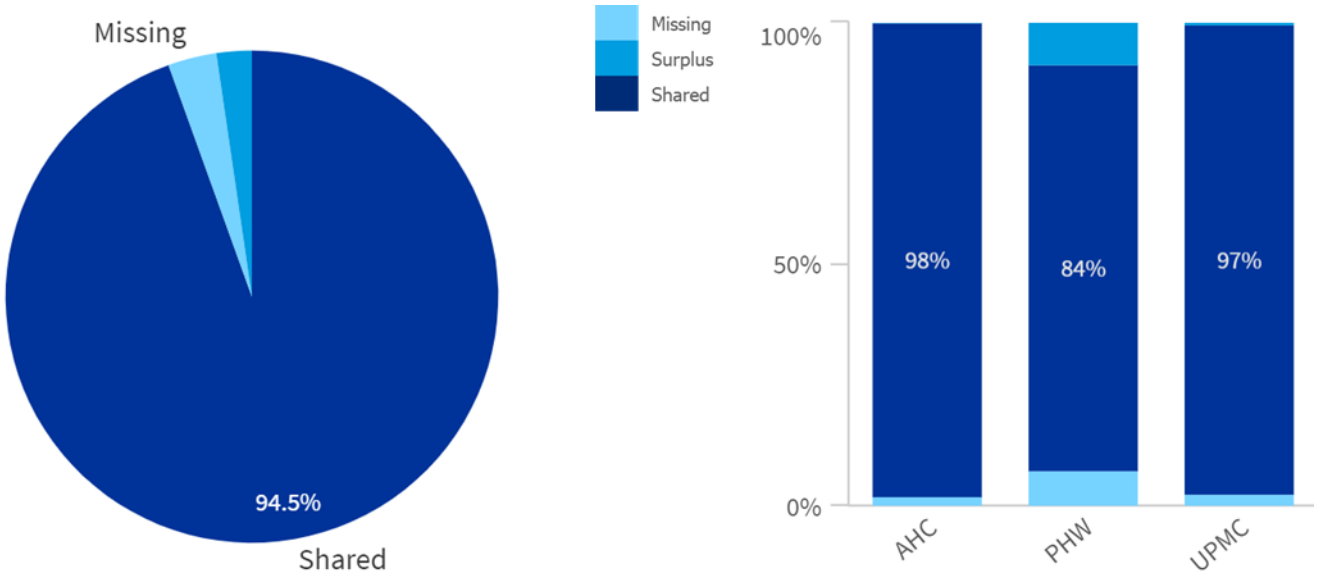
Professional

Below we provide a summary of ICN-level completeness results for the Professional claim form, which generally demonstrated the highest shared percentages across the three claim forms.

Graph: ICN Completeness — Professional Record Count



Graph: ICN Completeness — Professional Paid Amount



Key Observations Regarding ICN Completeness — Professional Claim Forms

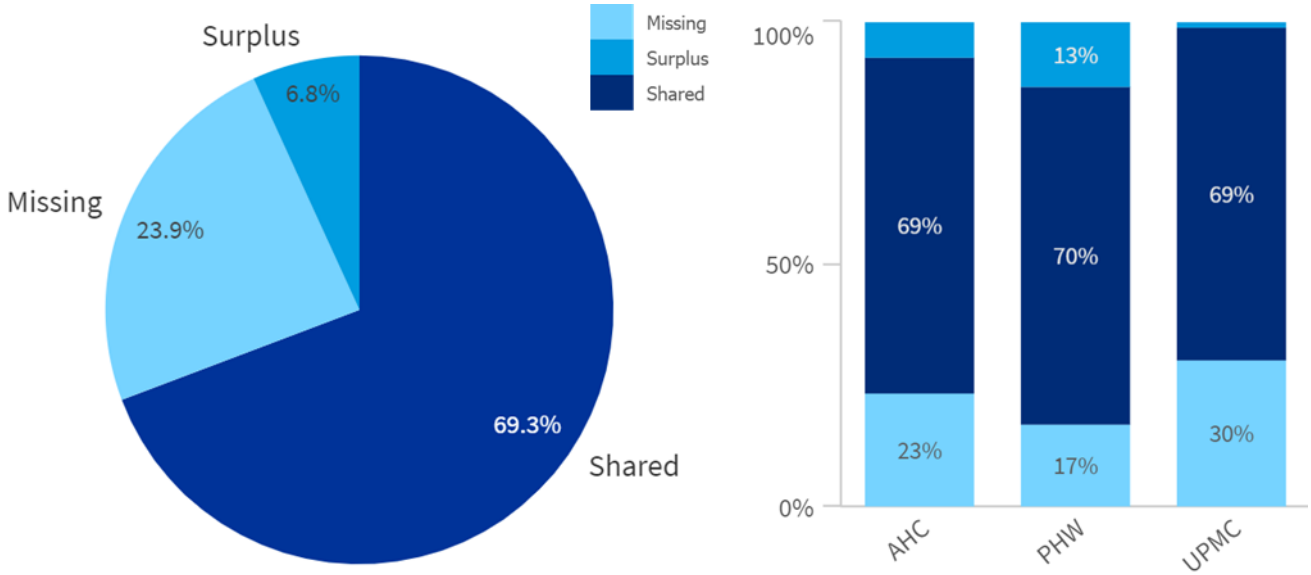
- Professional shared rates statewide were almost 91% (as measured by record count) and 95% (as measured by paid amount), suggesting that higher value records are more likely to be found in both the PROMISe encounters and CHC-MCO claims extract.
- Statewide shared rates for the Professional claim form are higher than the aggregate shared rates across all claims forms, which were approximately 82% when measured both by record count and paid amount. This indicates Professional encounters are, on average, more likely to match between the PROMISe data and CHC-MCO claims extracts.
- Most of the non-shared records were in the missing category, meaning more non-shared records were included in the CHC-MCO extract but not found in the PROMISe data than were identified PROMISe data and not found in the CHC-MCO extract.
- As measured by paid amount, the statewide shared rate for the Professional claim form was 95%, but the CHC-MCOs varied in their percentages of shared records. PHW showed a shared rate of 84% while AHC and UPMC had shared rates of 98% and 97%, respectively. This same general relationship held when measuring shared rates by record count.

ICN Completeness

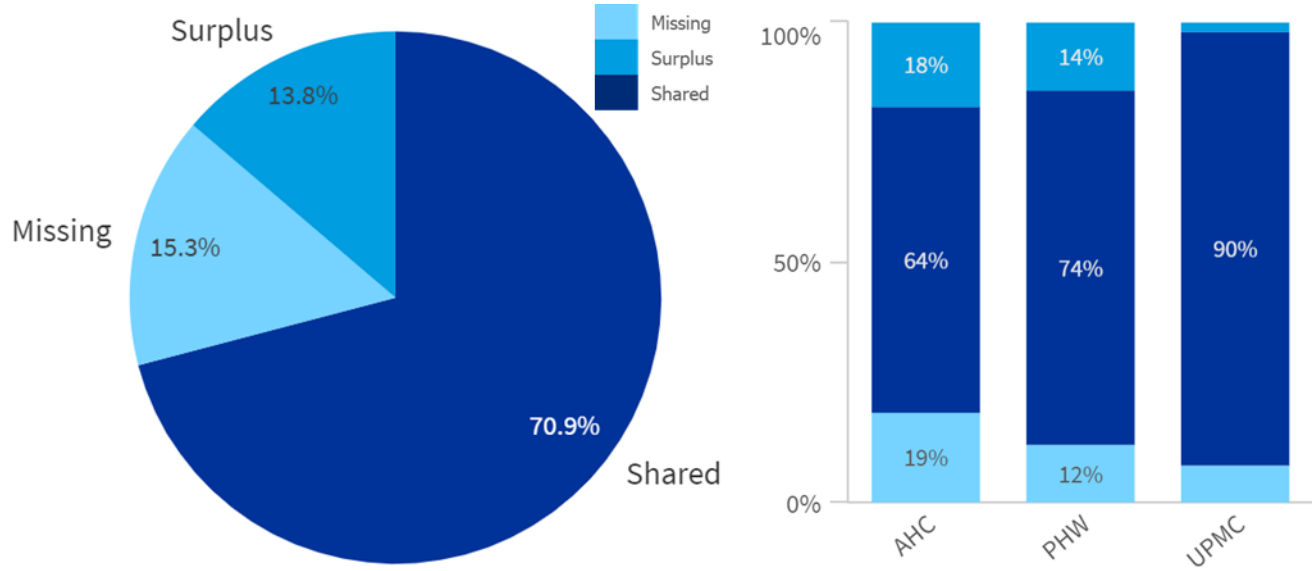
Pharmacy

Below we provide a summary of ICN-level completeness results for the Pharmacy claim form, which generally demonstrated lower shared rates than seen in the aggregate results that included all claims forms.

Graph: ICN Completeness — Pharmacy Record Count



Graph: ICN Completeness — Pharmacy Paid Amount



Key Observations Regarding ICN Completeness — Pharmacy Claim Forms

- Pharmacy shared rates are notably lower than shared rates across claims forms, and are also lower than the Professional claim form. As measured by record count, Pharmacy shared rates are 69.3% while the shared rates for all claim forms and for the Professional claims form are 81.5% and 90.8%, respectively. A similar relationship holds when shared rates are measured by paid amount.
- Statewide Pharmacy shared rates are consistent when measured across both record count (69.3%) and paid amount (70.9%), suggesting there is no notable difference statewide between the value of the shared and aggregate non-shared claims. However, the proportion of surplus records, as measured by record count, was much lower (6.8%) than when measured by paid amount (13.8%). This suggest the records found in the PROMISe data but not in the CHC-MCO extracts were generally higher dollar value encounters.
- The CHC-MCOs varied with respect to their proportions of non-shared records. When measured by record count, UPMC had the lowest proportion of surplus records at 1% (records found in the PROMISe data but not in UPMC's extract) and the highest proportion of missing records at 30% (in the UPMC extract and not in PROMISe data), while PHW had the largest proportion of surplus records at 13% and the lowest proportion of missing records at 17%. AHC fell between the other two plans with 23% missing and 7% surplus.
- The CHC-MCOs' individual shared rates were much more variable when measured by paid amount than when measured by record count. AHC had a lower shared rate as measured by paid amount (64%, compared to 69% for record count). PHW had a slightly higher shared rate of 74% (70% for record count), and UPMC had a notably higher shared rate of 90% (compared to 69% for record count). The difference demonstrated by UPMC, and to a lesser extent, PHW, suggests the shared records tend to represent higher dollar-value claims for these CHC-MCOs.

RECOMMENDATION: Mercer recommends DHS conduct additional investigation into the cause of the missing and surplus records identified for the Pharmacy claim form to understand if the results reflect an isolated issue related only to data sets in this audit or if there may be a more systemic issue related to Pharmacy data.

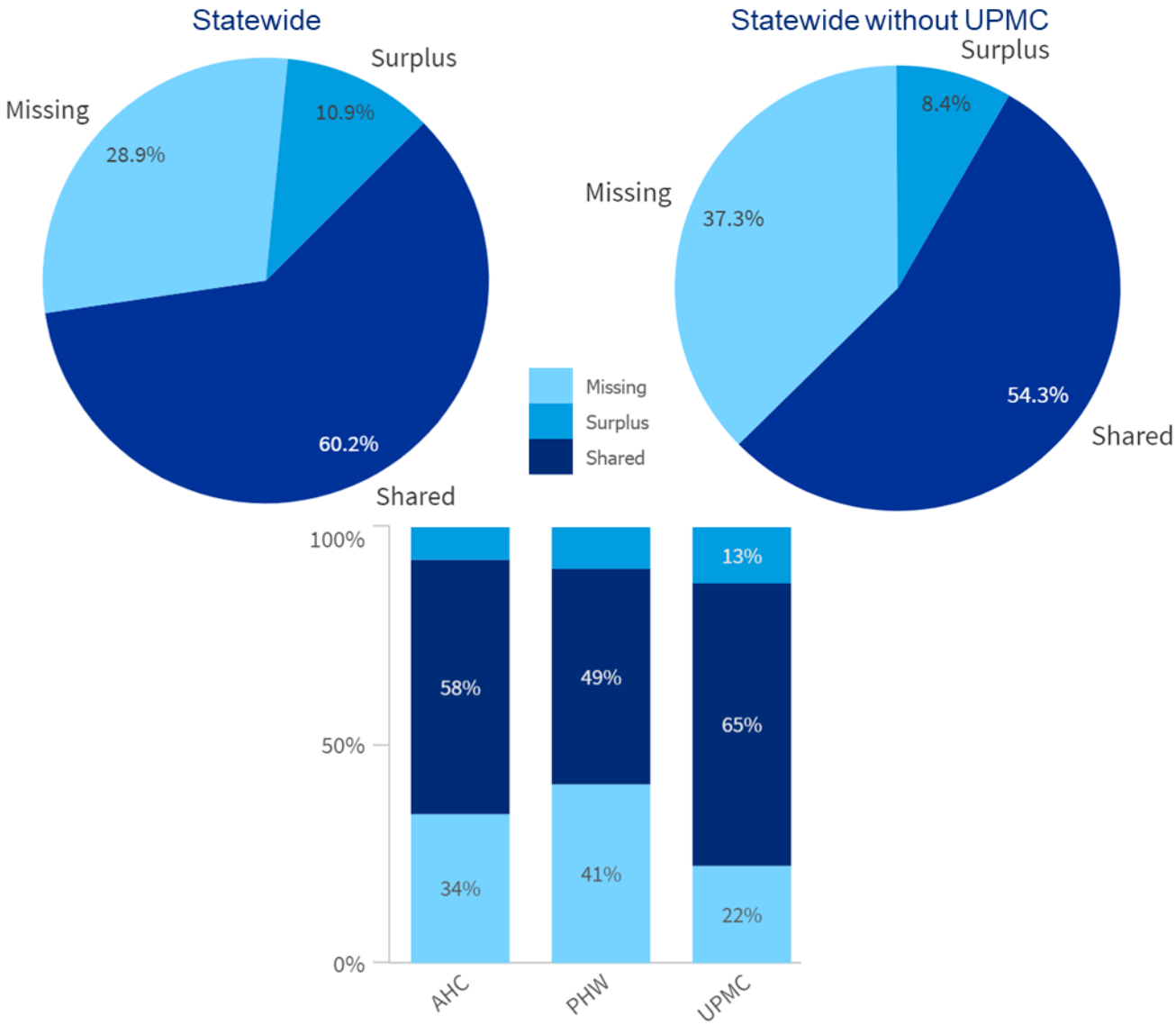
ICN Completeness

Institutional

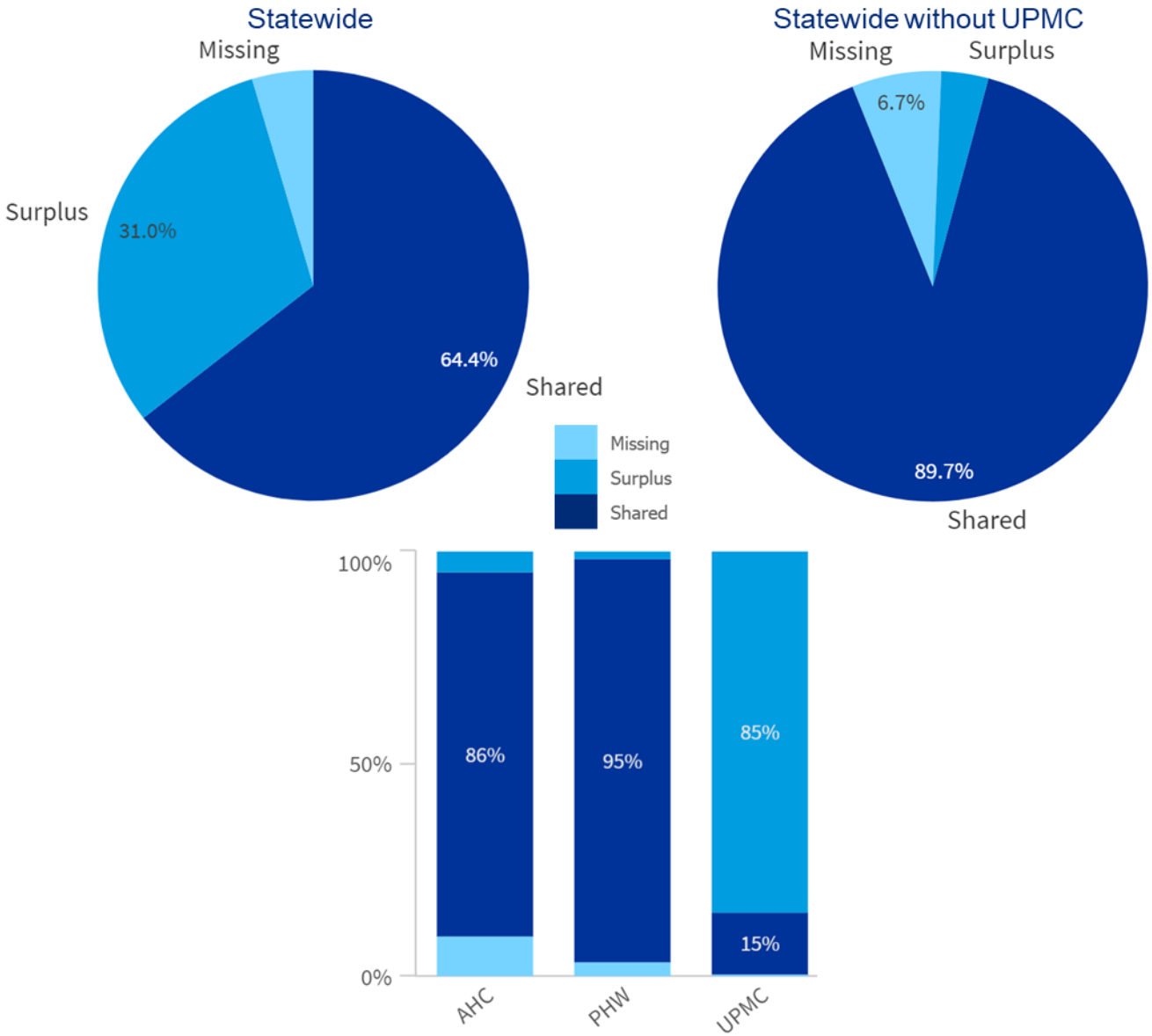
Below we provide a summary of ICN-level completeness results for the Institutional claim form, with additional analysis by Inpatient and Outpatient sub-type. In the course of our analysis, we identified notable issues with UPMC's Institutional data for both Inpatient and Outpatient services. As a result, Mercer is presenting several statewide results in this report in two ways: with and without UPMC Institutional data included. Because UPMC's identified

data issues may impact statewide results in a manner that is unrepresentative of the program as a whole, we provide this additional Statewide perspective without UPMC's data included.

Graph: ICN Completeness — Institutional Record Count



Graph: ICN Completeness — Institutional Paid Amount



Key Observations Regarding ICN Completeness — Institutional Claim Form

- Statewide, the shared record rates based on record count were 60.2% (with UPMC) and 54.2% (without UPMC), which is notably lower than the shared rates observed in aggregate (81.5%) and for Professional services (90.8%). These shared rates are somewhat lower than the shared rates for Pharmacy (69.3%). However, the shared rate increases markedly when measured by paid amount, particularly with the exclusion of UPMC in the statewide calculation. Specifically, the statewide shared rate excluding UPMC is almost 90%, comparable to the shared rate for the Professional claim form (94.5%) and greater than the aggregate shared rate across all claim forms (82.1%). The notable difference between the shared rates measured by record count and paid amount suggests shared records tend to be associated with more of the higher dollar claims.

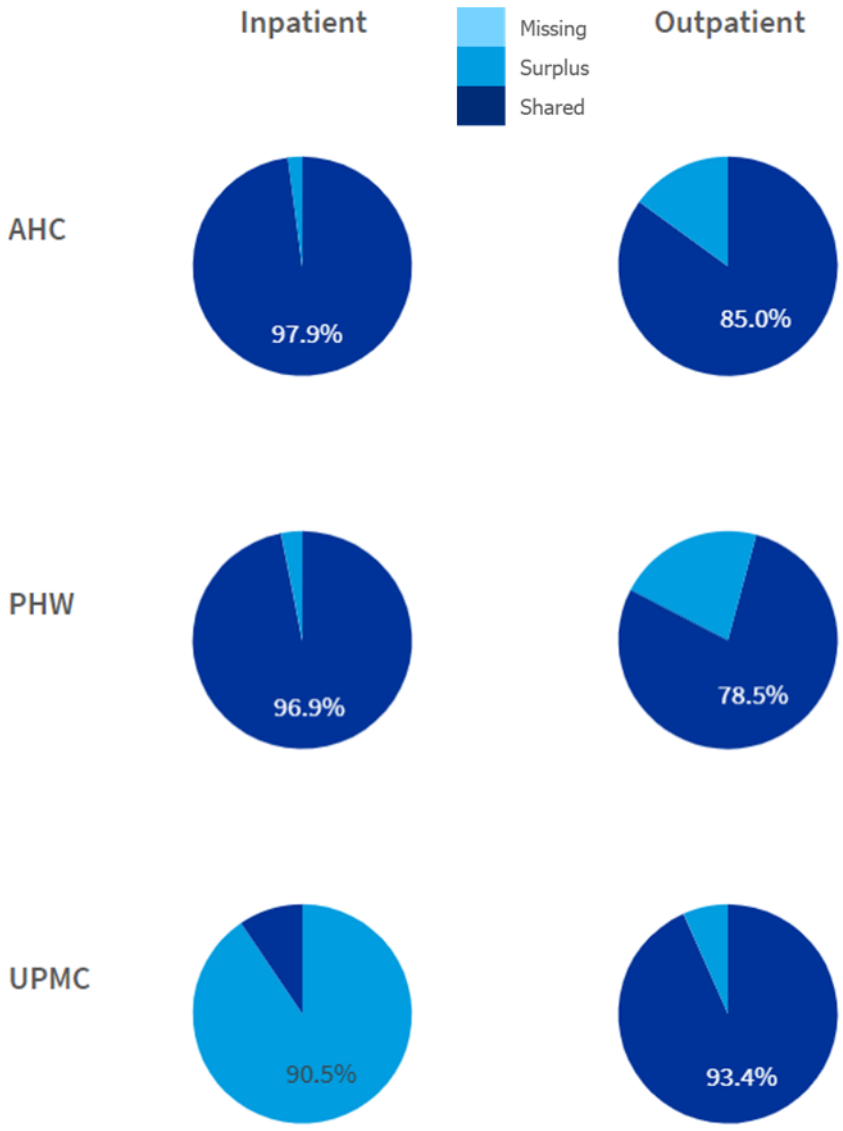
  86% and 95% of AHC and PHW's paid amounts, respectively, were associated with shared records, meaning almost 90% of statewide Institutional dollars were found in both data sources.

- When measured by record count, the majority of non-shared claims fell into the missing category, indicating a greater proportion of non-shared claims were in the CHC-MCO claims extracts but not found in the PROMISe data. While the missing category still represented the larger portion of non-shared claims when measured by paid amount with UPMC excluded, the percentage was relatively small.

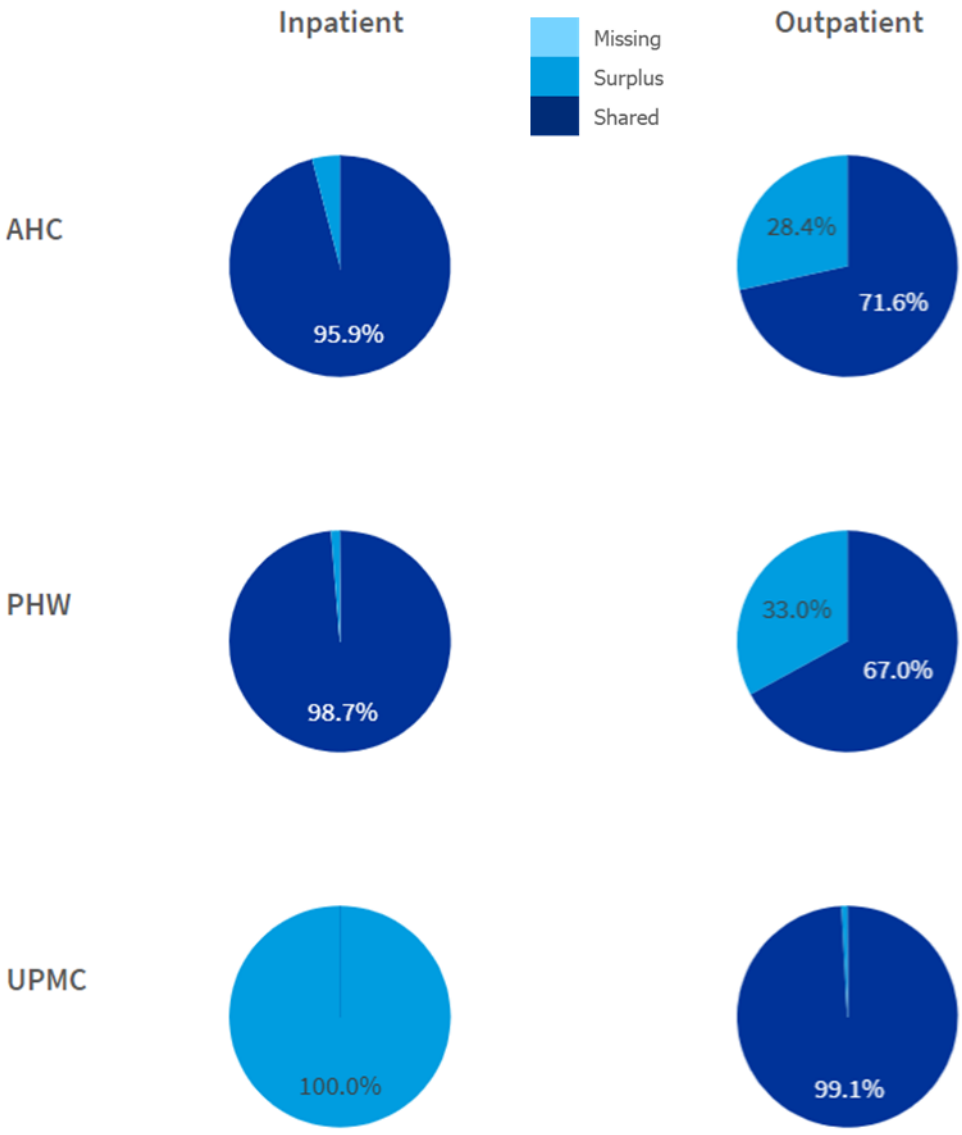
- While UPMC had the largest percentage of shared records when measured by record count, their shared record rate dropped to 15% when measured by paid amount. Specifically, 85% of paid dollars were associated with surplus records, indicating that a large number of dollars found in the PROMISe data did not align with data in the UPMC extract under the match criteria established for this audit.

Due to the unusual results we observed for UPMC's Institutional data, Mercer conducted additional analyses on the Institutional data. Specifically, using fields from the encounter data, we were able to analyze the shared and surplus records by Inpatient and Outpatient sub-type. The following graphs illustrate the results of this analysis.

Graph: ICN Completeness — Institutional Record Count by MCO and by Inpatient/Outpatient



Graph: ICN Completeness — Institutional Paid Amount by MCO and by Inpatient/Outpatient



Key Observations Regarding ICN Completeness — Institutional Claim Form Split by Inpatient and Outpatient Sub-Types

- When split by Inpatient and Outpatient sub-types, Mercer observed a significant number of surplus records associated with Inpatient services for UPMC, while their percentage of shared records for Outpatient services was relatively high. In fact, UPMC had the highest rate of shared records of all three CHC-MCOs for the Outpatient sub-type at 93.4% based on record count and 99.1% based on paid amount.
- When measured by paid amount, UPMC's surplus rate represented almost all of the dollars associated with the Inpatient surplus category. Specifically, $981 million in encounter data was unable to be matched to the claim data submitted by UPMC. Based

on a secondary analysis of these unmatched encounters, Mercer believes that Nursing Facility data may not be included in UPMC's claims data submission, which is more likely to indicate an issue with the claims data UPMC provided for this audit rather than a systemic difference between UPMC's claim and encounter data.

- While UPMC's Outpatient encounter data has a high rate of completeness, it is worth noting that Mercer identified significant irregularities in the Detail Amount Paid submitted on UPMC's Outpatient claims data.

RECOMMENDATION: Mercer recommends DHS conduct additional investigation into the data irregularities Mercer identified for UPMC to understand if the results reflect an isolated issue related only to data sets in this audit or if there may be a more systemic issue related to UPMC's Institutional data.

- For AHC and PHW, the percentage of paid amounts associated with shared records for the Inpatient sub-type (95.9% and 98.7%, respectively) was relatively consistent with the results as measured by record count (97.9% and 96.9%, respectively). However, for the Outpatient sub-type, the total paid amount associated with surplus records (28.4% and 33.0% respectively) was greater than when measured by record count (15% and 21.5%, respectively). This suggests the surplus records — those found in the PROMISe encounter data but not in the CHC-MCO's data extract — represented, on average, higher dollar Outpatient records.

Data Accuracy Results

In the Data Completeness analysis, we evaluated whether encounters can be found in both data sources. The Data Accuracy analysis builds on this step to determine whether shared records from the Data Completeness step above are populated *with matching values*. Beginning with the universe of shared records from the Data Completeness step above, we organized line-level data into the two categories below.

- **Matching**: the field is populated with identical values in both data sources
- **Not Matching**: the field is populated with different values between the two data sources

Please Note: Mercer's Data Accuracy analysis examines specific fields populated in both data sources to determine whether the fields are populated **with identical values.** It is important to note that Mercer's audit does not include an evaluation of the validity nor accuracy of the values contained in these fields.

Mercer performed each of these comparisons for all records in aggregate and for each claim form (Institutional, Professional, and Pharmacy). As with the previous analyses, we also analyzed data by record count as well as weighted by paid amount.

The graphs below present the field match rates by claim form. All rates are calculated as a percentage of shared records identified during the Data Completeness step above. For match rates, a higher rate indicates greater alignment between the two data sources.

Data Accuracy

All Claim Forms

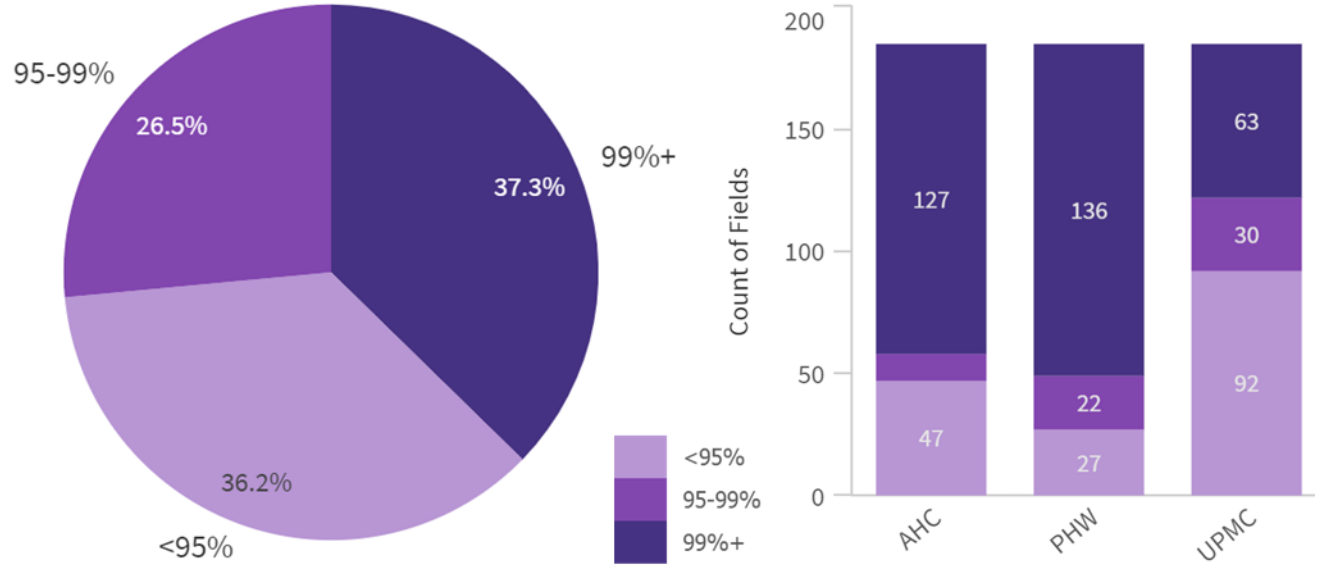
Across all claim forms, Mercer identified 185 fields for inclusion in the Data Accuracy analysis. The following graphs illustrate which of those fields have matching rates in one of three frequency ranges:

- Fields from the PROMISe encounter data and CHC-MCO data extract match at a rate greater than 99% **(99%+).**
- Fields from the PROMISe encounter data and CHC-MCO data extract match at a rate between 95% and 99% **(95%–99%).**
- Fields from the PROMISe encounter data and CHC-MCO data extract match at a rate less than 95% **(<95%).**

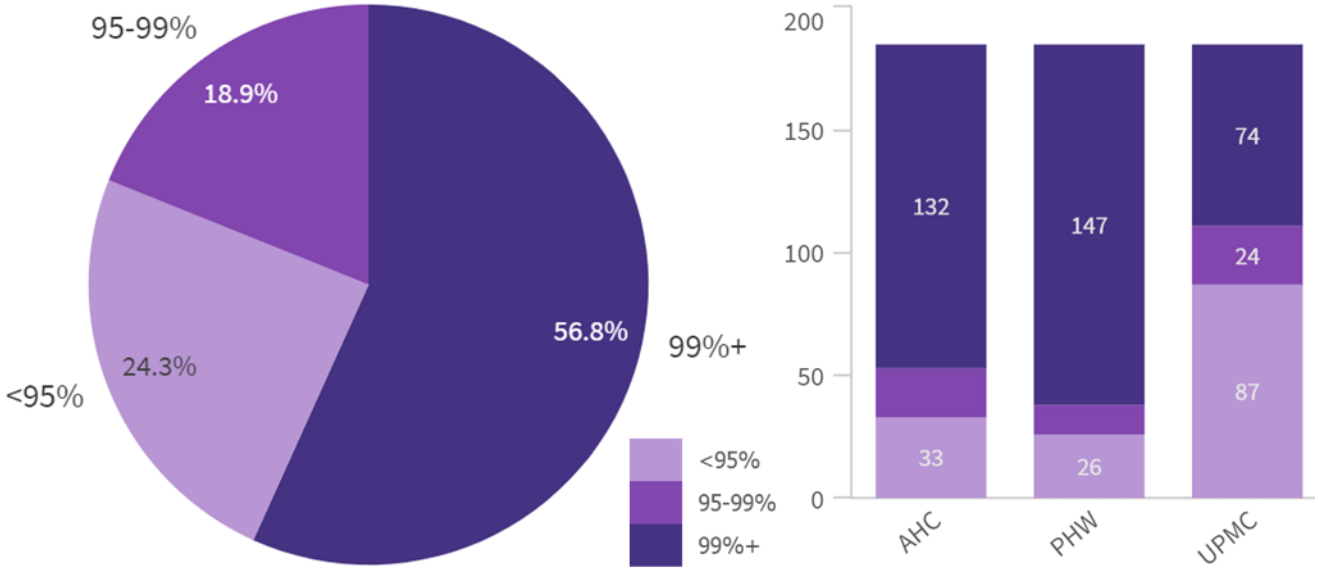
The pie chart on the left displays the results for all 185 fields across all CHC-MCOs, while the bar graph on the right illustrates each individual CHC-MCO's results across the 185 fields. Mercer calculated the Data Accuracy measures in two ways: weighted by record count and by paid amounts.

The Data Accuracy results for these fields are calculated based on shared records from the Data Completeness step. As described in the Data Completeness step, a significant share of UPMC's Institutional records were categorized as surplus (i.e., not shared). As a result, Data Accuracy measures from UPMC represent only a small portion of Inpatient records, as most were not classified as shared. Additionally, Mercer used the Detailed Amount Paid field in calculating Outpatient measures to be consistent with calculations for the other CHC-MCOs. As noted in the Data Completeness section, we found irregularities in that field during the Data Completeness step, which may impact the results in this section.

Graph: Data Accuracy — All Claim Forms Record Count



Graph: Data Accuracy — All Claim Forms Paid Amount



Key Observations Regarding Data Accuracy — All Claim Forms

- Statewide, for the 185 fields contained in this analysis, 37.3% had match rates above 99%, based on record count. However, that percentage increases to 56.2% when measured by paid amount, suggesting high match rates among higher-dollar records.
- Individual CHC-MCO results show UPMC to have match rates of 99%+ for notably fewer fields than do AHC and PHW. Specifically, based on record count, UPMC had only 34% of fields with a 99%+ match rate, where as AHC and PHW had 99%+ match rates for

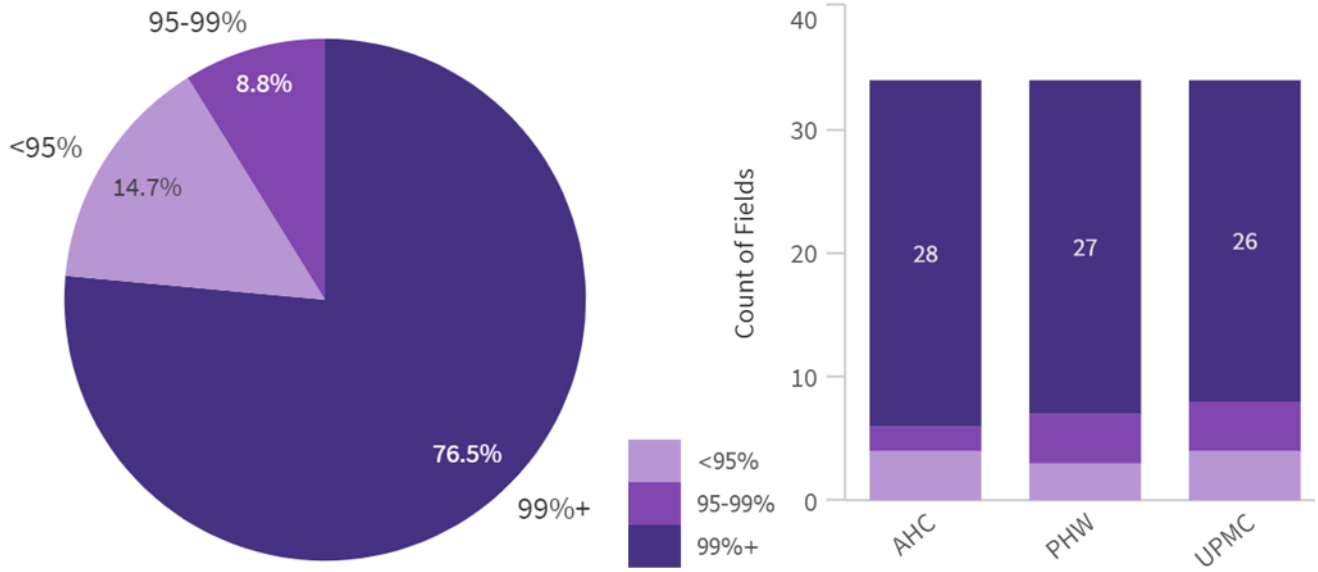
68.6% and 73.5% of fields, respectively. This same general relationship holds true when we measure match rates by paid amounts. As discussed above, the Institutional data issues identified for UPMC may impact these results.

Data Accuracy

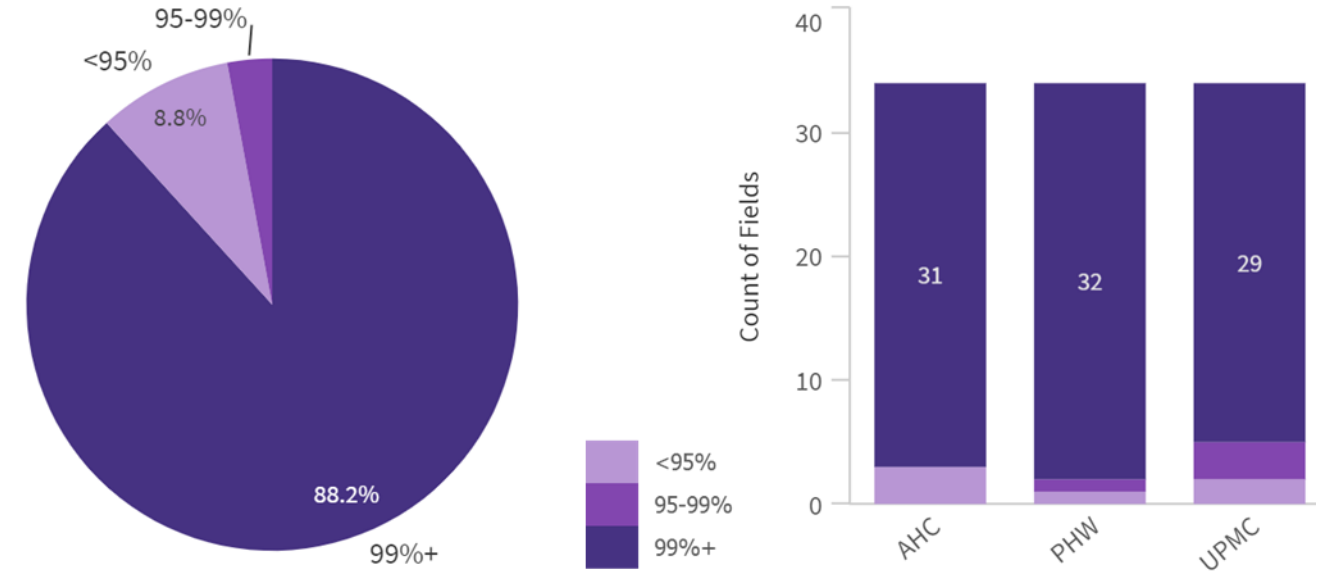
Professional

For Professional encounters, the following graphs illustrate the field match rate for the 34 fields included in the Professional claim form analysis.

Graph: Data Accuracy — Professional Record Count



Graph: Data Accuracy — Professional Paid Amount



Key Observations Regarding Data Accuracy — Professional Claim Form

- As seen in the earlier Data Integrity and Data Completeness analyses, the Professional data tend to demonstrate better overall results than found in the Pharmacy and Institutional claim forms. Statewide, 76.5% of fields showed a match rate of 99%+, as measured by record count. The match rate increases to 88.2% when measured by paid amount. Consistent with our other analyses, results from the paid amount measure tend to show greater alignment than results from the record count measure. This indicates that, across the program, higher value claims are more likely to align with encounter records than lower value claims.
- While the individual CHC-MCOs were relatively consistent with one another in their results for fields with match rates exceeding 99% (measured both by record count and paid amount), they had some variability in results for fields with rates below 99%.

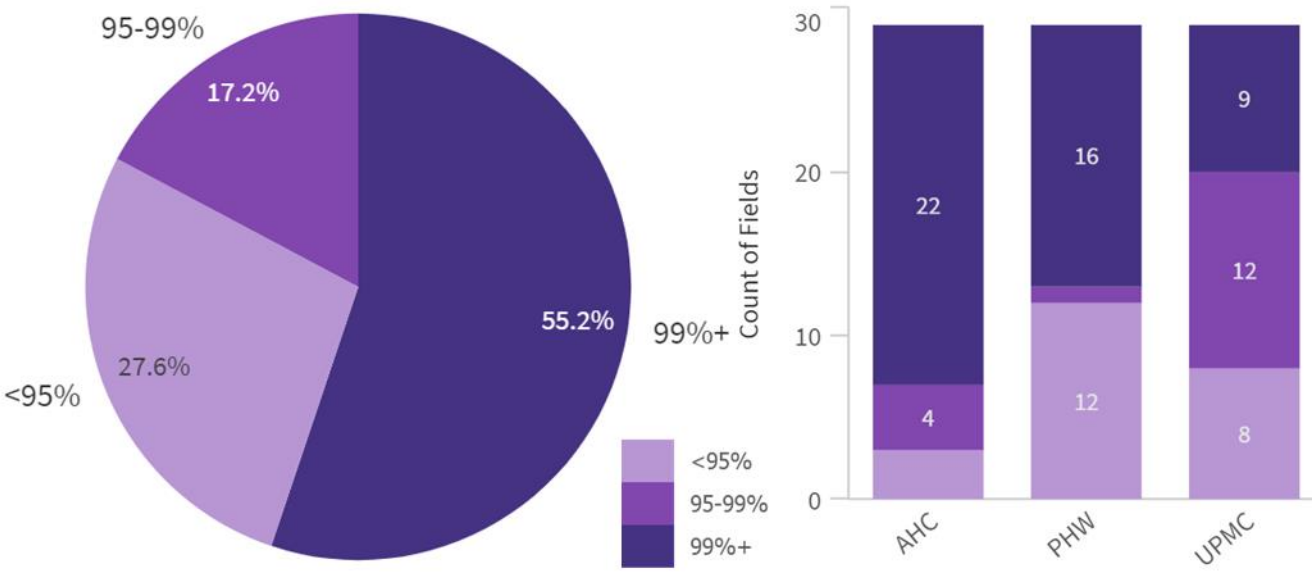
- The following fields fell into either the 95%–99% or less than 95% categories for at least one CHC-MCO, as measured by record count: Approved/Rejected Indicator, Capitation FFS Indicator, Detail Amount Paid, Detail Medicare Paid, Header Amount Billed, Header Amount Paid, Header Medicare Paid, MCO Paid Date, POS, and Performing Provider NPI.
- Of these fields, Performing Provider NPI for PHW (38.6%) was the lowest, with the next lowest being header Medicare Paid for PHW (79.9%). Of the 21 fields below 99% for at least one CHC-MCO, 12 were still above 90%.

Data Accuracy

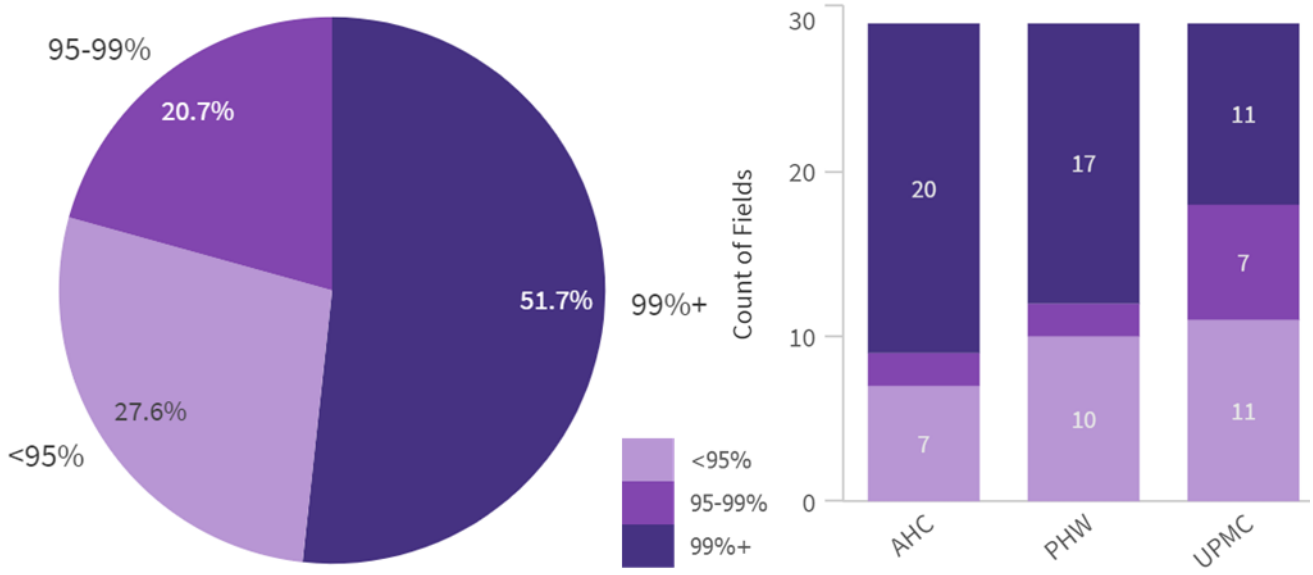
Pharmacy

For Pharmacy encounters, the following graphs illustrate the field match rate for the 29 fields included in the Pharmacy claim form analysis.

Graph: Data Accuracy — Pharmacy Record Count



Graph: Data Accuracy — Pharmacy Paid Amount



- Statewide, 55.2% of fields had match rates above 99%+ level as measured by record count, with 51.7% as measured by paid amount. Consistent with previous Pharmacy analyses, the overall results for Data Accuracy for the Pharmacy claim form are below the Professional claim form results. While in most other analyses, we tended to observe better results for the paid amount measure than for the record count measure, we see the opposite here. This suggests that, on average, fields which match are associated with lower-dollar value records.
- As demonstrated in the table below, results for the individual CHC-MCOs vary noticeably.

Table 6-1

CHC-MCO	<95%	95%–99%	99%+
AHC	10.3%	13.8%	75.9%
PHW	41.4%	3.4%	55.2%
UPMC	27.6%	41.4%	31.0%
Statewide	27.6%	17.2%	55.2%

This table illustrates results by record count, but similar variability exists in the paid amount measure.

- Mercer was informed that UPMC does not retain Prior Authorization Type on their claims data, which resulted in a match rate of 0% for this field. This is a known concern with UPMC's claims system and may not impact the encounter data.
- The following fields fell into either the 95%–99% or less than 95% categories for at least one CHC-MCO, as measured by record count: Approved/Rejected Indicator, Compound Prescription Indicator, Days Supply, Diagnosis 2, Diagnosis 3, Diagnosis 4, Diagnosis 5, Diagnosis 6, Diagnosis 7, Diagnosis 8, Diagnosis 9, Diagnosis 10, Diagnosis 11, HFDOS, Header Amount Billed, Header Amount Paid, Header Copay Amount, Header Medicare Paid, MCO Paid Date, NDC, Prescriber NPI, Prior Authorization Type, Quantity Dispensed.
- Only three fields demonstrated a match rate below 79% for at least one CHC-MCO. DHS may wish to prioritize these fields in future analysis: Compound Prescription indicator, Header Amount Billed, MCO Paid Date.

In recent years, Pharmacy encounters with Paid Amounts exceeding $1 million hit PROMISe system limitations. As a workaround, the CHC-MCOs are submitting these encounters with the system-allowed max amount of $999,999.99. The CHC-MCOs report actual Paid Amount information to the Bureau of Fiscal Management for risk mitigation settlement purposes, but PROMISe encounters do not therefore reflect the actual correct Paid Amounts. This practice was not accounted for in the audit methodology, and could therefore influence results for these records.

Data Accuracy

Institutional

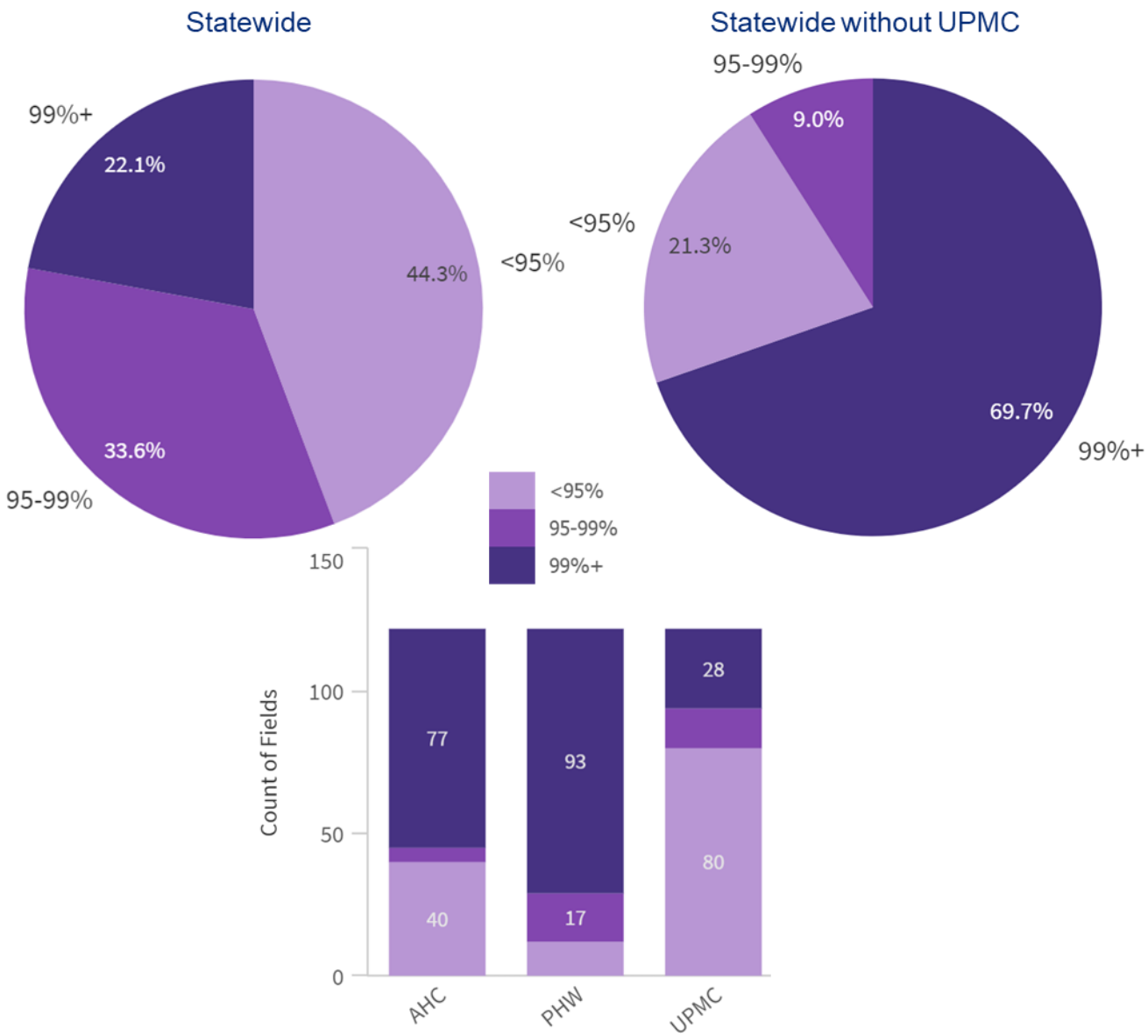
For Institutional encounters, the following graphs illustrate the field match rate for the 122 fields included in the Institutional analysis.

As indicated earlier, Mercer identified significant issues with UPMC's Institutional data. Specifically, for the Outpatient data, Mercer identified irregularities in the Detail Amount Paid

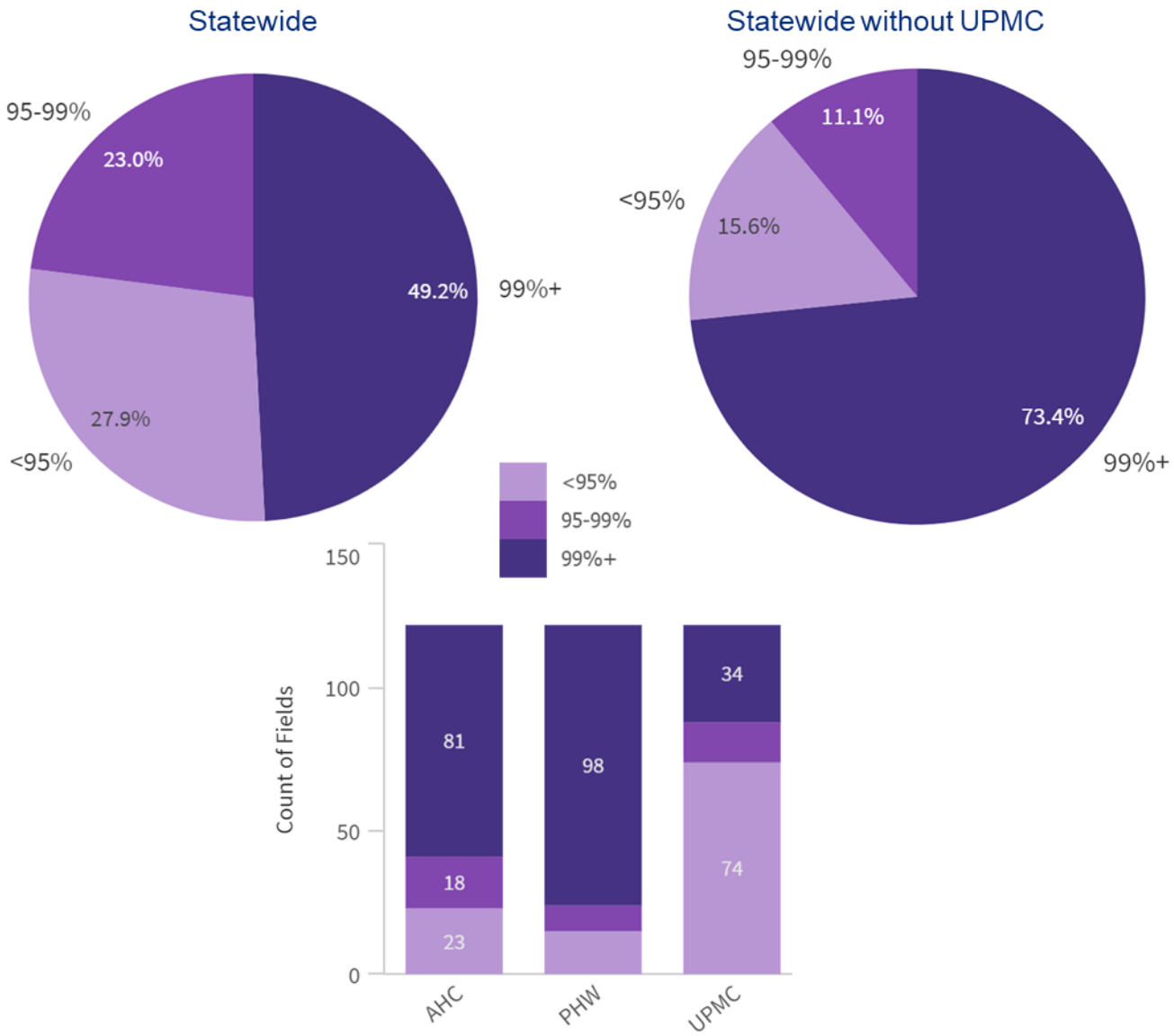
field during the ICN Completeness step. However, we calculated Outpatient Data Accuracy using this Detail Amount Paid data to be consistent with other CHC-MCOs.

Additionally, because the Data Accuracy measures are based only on shared data and do not include surplus records, only a very small portion of UPMC inpatient data is included in this analysis. As a result, we cannot extrapolate these results across all UPMC Inpatient claims and encounters. As a result of these known issues, we have again provided Statewide results with and without UPMC data included.

Graph: Data Accuracy — Institutional Record Count



Graph: Data Accuracy — Institutional Paid Amount



Key Observations Regarding Data Accuracy — Institutional Claim Form

- Statewide, 22.1% of fields exhibit match rates above 99% with UPMC records included. This rises to 69.7% of fields when UPMC is excluded, as measured using record counts. This is a significant difference, which reflects the concerns with UPMC data.
- As we saw in other analyses, when measured by paid amounts, statewide match rates (without UPMC) tend to improve. The percentage of fields for the other two CHC-MCOs with match rates above 99% increases from 69.7% to 73.4% when calculated using paid amount and increases from 9.0% to 11.1% for fields with match rates between 95% to 99%.

- While UPMC matches at rate above 99% for the Modifier 3 and 4 fields, these fields were found to be entirely blank on UPMC encounters during the Population Integrity step. This means that UPMC is not submitting some values on encounters found in both data sources.

RECOMMENDATION: Mercer recommends that DHS ask UPMC to begin submitting Modifier 2, 3, and 4 values on encounters.

- For AHC, Type of Bill matched for 0.0% of records. This likely indicates an issue with AHC's claims submission provided during this audit. Other fields below a 70% match, which may benefit from additional analysis, include: Covered Days, Header Medicare Paid, Header Amount Billed, CPT/HCPCS Procedure Code, and Revenue Code.
- For PHW, the field with the lowest match rate was Header Medicare Paid (27.63%). Other fields below a 80% match, which may benefit from additional analysis, include: MCO DRG Type, Header Medicare Paid, and Covered Days.

7. Conclusion

Mercer's qualitative findings from the CHC encounter and financial data audit suggest DHS generally has the systems and processes in place to appropriately monitor and ensure the quality of encounter data. Additionally, each CHC-MCO has the systems and capabilities to generate timely and accurate encounter data. The results of our assessment of the encounter and claims data provided for this audit were variable and, in some cases, inconclusive. While some assessment areas — such as Population Integrity and Reasonableness Integrity — showed strong results, there are several areas in which we suggest DHS conduct additional investigation to determine whether the results of this analysis are driven by one-time issues associated with the data provided for this audit or are representative of larger systemic issues.

While performance in many aspects of this audit was strong, there remain areas for improvement, as we noted throughout this report. A summary of the overall observations by audit activity is contained in the table below.

OVERALL RESULTS

For each of the major categories of analyses Mercer conducted, we found the following:

- Overall, the program displays an expected degree of encounter data quality given that CY 2020 represents the first year of statewide program implementation
- Most fields in the CHC encounter data which are expected to be populated are populated in a high number of instances. When fields are able to be assessed for reasonability, they generally contain reasonable values.
- An acceptable degree of matching records was observed for Professional and Pharmacy claim forms for all CHC-MCOs and for Institutional claim forms for two of three CHC-MCOs.
- The accuracy of CHC encounter data could be improved for all CHC-MCOs.
- We discovered several issues with UPMC's Institutional data that DHS should further investigate to understand the scope of the issue. This compromised the audit's ability to produce meaningful conclusions for UPMC Nursing Facility records, a major source of program cost.

As discussed earlier, CHC is a relatively new managed care program, and the time period for this audit (CY 2020) corresponds to the first year of full program implementation. As with the implementation of any new program, complications inevitably arise, especially with respect to data. Readers should consider the results of this report in that context and with the understanding that DHS and the CHC-MCOs are continually assessing and implementing processes and systems for performance improvement as the program matures.

Appendix A
Data Analytics Results for all CHC-MCOs

Table A-1: Population Integrity: Institutional

Institutional		Population Integrity — Population Rate							
		Record Count Results				Paid Amount Results			
Field Name	Claim Form	Statewide	AHC	PHW	UPMC	Statewide	AHC	PHW	UPMC
Admission Date	Inpatient	100.00%	100.00%	99.99%	100.00%	100.00%	100.00%	100.00%	100.00%
Admission Source	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Admission Source	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Approved/ Rejected Indicator	Outpatient	99.36%	98.25%	98.01%	99.99%	99.19%	97.22%	99.99%	99.85%
Approved/ Rejected Indicator	Outpatient	99.89%	99.74%	99.99%	99.94%	99.94%	100.00%	100.00%	99.82%
Billing Provider NPI	Inpatient	99.99%	100.00%	100.00%	99.97%	100.00%	100.00%	100.00%	99.99%
Billing Provider NPI	Inpatient	99.99%	100.00%	100.00%	99.99%	100.00%	100.00%	100.00%	100.00%
Capitation FFS Indicator	Outpatient	98.29%	99.98%	93.53%	100.00%	100.00%	100.00%	100.00%	100.00%
Capitation FFS Indicator	Inpatient	97.42%	99.98%	82.41%	100.00%	100.00%	99.99%	100.00%	100.00%
Covered Days	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Covered Days	Outpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
CPT/HCPCS Procedure Code	Inpatient	98.07%	98.40%	97.05%	98.20%	99.10%	97.02%	99.96%	99.80%
Detail Amount Paid	Outpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Detail Copay Amount	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Institutional		Population Integrity — Population Rate							
		Record Count Results				Paid Amount Results			
Field Name	Claim Form	Statewide	AHC	PHW	UPMC	Statewide	AHC	PHW	UPMC
DFDOS	Outpatient	99.98%	99.92%	100.00%	100.00%	99.19%	97.25%	99.99%	99.85%
Diagnosis 1	Outpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Diagnosis 1	Outpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Header Amount Billed	Outpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Header Amount Billed	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Header Amount Paid	Outpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Header Amount Paid	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Header Copay Amount	Outpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Header Medicare Paid	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Header Medicare Paid	Outpatient	99.98%	99.92%	100.00%	100.00%	99.19%	97.25%	99.99%	99.85%
HFDOS	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
HFDOS	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
MCO Code	Outpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
MCO Code	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
MCO DRG	Outpatient	61.71%	69.75%	58.50%	56.82%	12.70%	20.27%	6.92%	9.69%
MCO DRG Type	Inpatient	72.57%	72.85%	65.56%	77.03%	13.42%	21.24%	7.58%	10.21%
MCO Paid Date	Outpatient	100.00%	100.00%	100.00%	99.99%	100.00%	100.00%	100.00%	100.00%
MCO Paid Date	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Present on Admission 1	Outpatient	65.54%	73.71%	65.47%	58.43%	13.57%	21.78%	7.54%	10.09%
Recipient ID Number	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Institutional		Population Integrity — Population Rate							
		Record Count Results				Paid Amount Results			
Field Name	Claim Form	Statewide	AHC	PHW	UPMC	Statewide	AHC	PHW	UPMC
Recipient ID Number	Outpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Revenue Code	Outpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Type of Admission	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Type of Admission	Outpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Type of Bill	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Type of Bill	Outpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Table A-2: Population Integrity: Professional

Professional	Population Integrity — Population Rate							
	Record Count Results				Paid Amount Results			
Field Name	Statewide	AHC	PHW	UPMC	Statewide	AHC	PHW	UPMC
Approved/Rejected Indicator	99.95%	99.93%	99.99%	99.98%	99.99%	100.00%	99.99%	99.99%
Billing Provider NPI	36.37%	16.20%	75.57%	44.72%	25.01%	5.48%	69.61%	25.13%
Capitation FFS Indicator	99.24%	100.00%	96.61%	99.99%	100.00%	100.00%	100.00%	100.00%
CPT/HCPCS Procedure Code	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Detail Amount Paid	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Detail Copay Amount	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
DFDOS	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Diagnosis 1	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Header Amount Billed	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Header Amount Paid	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Header Copay Amount	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Header Medicare Paid	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
HFDOS	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
MCO Code	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
MCO Paid Date	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Performing Provider NPI	42.04%	27.11%	75.55%	44.15%	25.20%	6.07%	69.60%	24.62%
POS	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Recipient ID Number	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Table A-3: Population Integrity: Pharmacy

Pharmacy	Population Integrity — Population Rate							
	Record Count Results				Paid Amount Results			
Field Name	Statewide	AHC	PHW	UPMC	Statewide	AHC	PHW	UPMC
Approved/Rejected Indicator	99.99%	100.00%	100.00%	99.96%	100.00%	100.00%	100.00%	100.00%
Billing Provider NPI	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Compound Prescription Indicator	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Days Supply	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Header Amount Billed	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Header Amount Paid	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Header Copay Amount	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Header Medicare Paid	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
HFDOS	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
MCO Code	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
MCO Paid Date	100.00%	100.00%	100.00%	99.98%	100.00%	100.00%	100.00%	100.00%
NDC	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Prescriber NPI	99.99%	100.00%	100.00%	99.95%	99.98%	100.00%	100.00%	99.93%
Prior Authorization Type	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Quantity Dispensed	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Recipient ID Number	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Table A-4: Reasonableness Integrity: Institutional

Institutional		Reasonableness Integrity — Reasonableness Rate							
		Record Count Results				Paid Amount Results			
Field Name	Claim Form	Statewide	AHC	PHW	UPMC	Statewide	AHC	PHW	UPMC
Admission Source	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Admission Source	Outpatient	100.00%	100.00%	99.99%	100.00%	100.00%	100.00%	100.00%	100.00%
Billing Provider NPI	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Billing Provider NPI	Outpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
CPT/HCPCS Procedure Code	Outpatient	99.79%	99.57%	99.47%	99.93%	99.72%	99.14%	99.64%	99.94%
Diagnosis 1	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Institutional		Reasonableness Integrity — Reasonableness Rate							
		Record Count Results				Paid Amount Results			
Field Name	Claim Form	Statewide	AHC	PHW	UPMC	Statewide	AHC	PHW	UPMC
Diagnosis 1	Outpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
ICD-10[12] Procedure Code 1	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
ICD-10 Procedure Code 2	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
ICD-10 Procedure Code 3	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
ICD-10 Procedure Code 4	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
ICD-10 Procedure Code 5	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
ICD-10 Procedure Code 6	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Modifier 1	Outpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Modifier 2	Outpatient	100.00%	100.00%	100.00%	NA*	100.00%	100.00%	100.00%	NA*
Modifier 3	Outpatient	100.00%	100.00%	99.99%	NA*	100.00%	100.00%	100.00%	NA*
Modifier 4	Outpatient	100.00%	100.00%	100.00%	NA*	100.00%	100.00%	100.00%	NA*
Revenue Code	Outpatient	99.97%	99.98%	99.95%	99.97%	99.99%	99.99%	99.97%	99.99%
Type of Admission	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Type of Admission	Outpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Type of Bill	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Type of Bill	Outpatient	99.91%	99.98%	99.56%	99.97%	100.00%	100.00%	99.95%	100.00%

Table A-5: Reasonableness Integrity: Professional

Professional	Reasonableness Integrity — Reasonableness Rate							
	Record Count Results				Paid Amount Results			
Field Name	Statewide	AHC	PHW	UPMC	Statewide	AHC	PHW	UPMC
Billing Provider NPI	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
CPT/HCPCS Procedure Code	99.46%	99.52%	99.38%	99.40%	99.63%	99.75%	99.30%	99.70%

[12] International Classification of Diseases, Tenth Edition (ICD-10).

Professional	Reasonableness Integrity — Reasonableness Rate							
	Record Count Results				Paid Amount Results			
Field Name	Statewide	AHC	PHW	UPMC	Statewide	AHC	PHW	UPMC
Diagnosis 1	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Modifier 1	99.87%	99.94%	99.93%	99.72%	99.94%	99.97%	99.98%	99.87%
Modifier 2	99.99%	100.00%	100.00%	99.98%	99.99%	99.99%	100.00%	99.99%
Modifier 3	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Modifier 4	99.99%	100.00%	100.00%	99.98%	100.00%	100.00%	100.00%	100.00%
Performing Provider NPI	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
POS	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Table A-6: Reasonableness Integrity: Pharmacy

Pharmacy	Reasonableness Integrity — Reasonableness Rate							
	Record Count Results				Paid Amount Results			
Field Name	Statewide	AHC	PHW	UPMC	Statewide	AHC	PHW	UPMC
Billing Provider NPI	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
DAW[13]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Diagnosis 1	100.00%	100.00%	99.99%	100.00%	100.00%	100.00%	100.00%	100.00%
NDC	99.95%	99.96%	99.90%	99.95%	99.98%	99.98%	99.96%	99.98%
Prescriber NPI	100.00%	100.00%	100.00%	100.00%	100.00%	99.99%	100.00%	100.00%
Prior Authorization Type	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Table A-7: Data Accuracy: Institutional

Institutional		Data Accuracy — Match Rate							
		Record Count Results				Paid Amount Results			
Field Name	Claim Form	Statewide	AHC	PHW	UPMC	Statewide	AHC	PHW	UPMC
Admission Date	Inpatient	99.99%	100.00%	99.99%	100.00%	100.00%	100.00%	100.00%	100.00%
Admission Source	Inpatient	99.97%	100.00%	100.00%	99.44%	100.00%	100.00%	100.00%	99.93%
Admission Source	Outpatient	99.98%	100.00%	100.00%	99.97%	99.96%	100.00%	100.00%	99.95%
Approved/Rejected Indicator	Inpatient	89.56%	89.76%	97.34%	34.14%	99.92%	99.86%	99.99%	98.32%
Approved/Rejected Indicator	Outpatient	65.40%	90.03%	81.96%	55.61%	99.79%	99.91%	100.00%	99.75%

[13] Dispensed as written (DAW).

Institutional		Data Accuracy — Match Rate							
		Record Count Results				Paid Amount Results			
Field Name	Claim Form	Statewide	AHC	PHW	UPMC	Statewide	AHC	PHW	UPMC
Billing Provider NPI	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Billing Provider NPI	Outpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Capitation FFS Indicator	Inpatient	77.40%	77.44%	88.60%	0.00%	60.10%	25.66%	99.51%	0.00%
Capitation FFS Indicator	Outpatient	23.33%	70.09%	80.19%	0.00%	17.10%	59.85%	99.92%	0.00%
Covered Days	Inpatient	44.63%	27.91%	59.14%	96.72%	54.01%	95.12%	7.02%	8.90%
Covered Days	Outpatient	99.37%	99.95%	95.47%	99.94%	99.62%	99.85%	93.40%	99.96%
CPT/HCPCS Procedure Code	Outpatient	70.44%	52.59%	98.96%	69.96%	66.72%	50.74%	99.56%	68.88%
Detail Amount Paid	Outpatient	69.65%	82.80%	99.53%	60.49%	21.49%	50.36%	98.65%	8.53%
Detail Copay Amount	Outpatient	99.98%	99.88%	100.00%	100.00%	99.90%	99.50%	100.00%	100.00%
DFDOS	Outpatient	51.73%	85.59%	98.45%	33.80%	36.20%	88.42%	99.84%	17.79%
Diagnosis 1	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Diagnosis 1	Outpatient	100.00%	100.00%	99.99%	100.00%	100.00%	100.00%	100.00%	100.00%
Diagnosis 10	Inpatient	98.26%	99.27%	99.99%	77.16%	99.82%	99.68%	99.99%	71.57%
Diagnosis 10	Outpatient	90.05%	99.99%	100.00%	85.49%	94.06%	100.00%	100.00%	92.05%
Diagnosis 11	Inpatient	98.24%	99.22%	99.99%	77.22%	99.81%	99.67%	99.99%	71.85%
Diagnosis 11	Outpatient	91.82%	99.99%	100.00%	88.08%	95.18%	100.00%	100.00%	93.55%
Diagnosis 12	Inpatient	98.23%	99.19%	99.99%	77.33%	99.82%	99.67%	99.99%	71.87%
Diagnosis 12	Outpatient	93.01%	99.99%	100.00%	89.81%	95.87%	100.00%	100.00%	94.47%
Diagnosis 13	Inpatient	98.20%	99.15%	99.99%	77.16%	99.80%	99.65%	99.99%	72.32%
Diagnosis 13	Outpatient	93.82%	99.99%	100.00%	91.00%	96.31%	100.00%	100.00%	95.06%
Diagnosis 14	Inpatient	98.20%	99.14%	99.99%	77.21%	99.81%	99.65%	99.99%	72.34%
Diagnosis 14	Outpatient	94.51%	99.99%	100.00%	92.00%	96.58%	100.00%	100.00%	95.42%
Diagnosis 15	Inpatient	98.21%	99.15%	100.00%	77.32%	99.81%	99.65%	99.99%	72.37%
Diagnosis 15	Outpatient	95.11%	99.99%	100.00%	92.87%	96.82%	100.00%	100.00%	95.75%
Diagnosis 16	Inpatient	98.19%	99.12%	99.99%	77.39%	99.79%	99.63%	99.99%	72.37%
Diagnosis 16	Outpatient	95.63%	99.99%	99.99%	93.64%	97.08%	100.00%	100.00%	96.09%
Diagnosis 17	Inpatient	98.19%	99.10%	99.99%	77.48%	99.79%	99.63%	99.99%	69.34%
Diagnosis 17	Outpatient	96.12%	99.99%	99.99%	94.34%	97.33%	100.00%	100.00%	96.43%
Diagnosis 18	Inpatient	98.20%	99.09%	99.99%	77.72%	99.79%	99.63%	99.99%	72.83%
Diagnosis 18	Outpatient	96.57%	100.00%	99.99%	95.00%	97.48%	100.00%	100.00%	96.63%

Institutional		Data Accuracy — Match Rate							
		Record Count Results				Paid Amount Results			
Field Name	Claim Form	Statewide	AHC	PHW	UPMC	Statewide	AHC	PHW	UPMC
Diagnosis 19	Inpatient	98.23%	99.12%	100.00%	77.97%	99.84%	99.71%	99.99%	72.83%
Diagnosis 19	Outpatient	96.99%	100.00%	99.99%	95.61%	97.61%	100.00%	100.00%	96.81%
Diagnosis 2	Inpatient	98.41%	99.86%	99.19%	79.83%	98.82%	99.89%	97.61%	71.64%
Diagnosis 2	Outpatient	43.59%	100.00%	99.99%	17.73%	40.48%	100.00%	100.00%	20.36%
Diagnosis 20	Inpatient	98.36%	99.10%	100.00%	80.34%	99.83%	99.70%	100.00%	72.83%
Diagnosis 20	Outpatient	97.52%	99.99%	99.99%	96.39%	98.70%	100.00%	100.00%	98.26%
Diagnosis 21	Inpatient	98.44%	99.23%	100.00%	80.57%	99.88%	99.78%	100.00%	73.28%
Diagnosis 21	Outpatient	97.86%	100.00%	99.99%	96.88%	99.04%	100.00%	100.00%	98.71%
Diagnosis 22	Inpatient	98.48%	99.26%	100.00%	80.85%	99.88%	99.79%	99.99%	73.76%
Diagnosis 22	Outpatient	98.20%	100.00%	99.99%	97.38%	99.39%	100.00%	100.00%	99.19%
Diagnosis 23	Inpatient	98.51%	99.29%	100.00%	81.26%	99.89%	99.80%	100.00%	73.78%
Diagnosis 23	Outpatient	98.48%	100.00%	100.00%	97.79%	99.50%	100.00%	100.00%	99.33%
Diagnosis 24	Inpatient	98.55%	99.35%	100.00%	81.41%	99.89%	99.80%	100.00%	73.78%
Diagnosis 24	Outpatient	98.68%	100.00%	100.00%	98.07%	99.56%	100.00%	100.00%	99.41%
Diagnosis 25	Inpatient	98.68%	99.49%	100.00%	82.27%	99.93%	99.87%	100.00%	73.80%
Diagnosis 25	Outpatient	98.88%	100.00%	100.00%	98.37%	99.63%	100.00%	100.00%	99.50%
Diagnosis 3	Inpatient	98.65%	99.70%	100.00%	79.83%	99.92%	99.86%	99.99%	71.64%
Diagnosis 3	Outpatient	46.76%	100.00%	99.99%	22.34%	42.49%	100.00%	100.00%	23.06%
Diagnosis 4	Inpatient	98.60%	99.62%	100.00%	79.83%	99.91%	99.84%	99.99%	71.64%
Diagnosis 4	Outpatient	50.03%	100.00%	99.99%	27.11%	45.18%	100.00%	100.00%	26.66%
Diagnosis 5	Inpatient	98.57%	99.57%	99.99%	79.69%	99.90%	99.83%	99.99%	71.64%
Diagnosis 5	Outpatient	55.28%	99.99%	99.99%	34.78%	50.16%	100.00%	100.00%	33.32%
Diagnosis 6	Inpatient	98.54%	99.52%	99.99%	79.64%	99.89%	99.81%	99.99%	71.64%
Diagnosis 6	Outpatient	64.28%	99.99%	99.99%	47.90%	62.19%	100.00%	100.00%	49.41%
Diagnosis 7	Inpatient	98.35%	99.46%	99.99%	76.95%	99.88%	99.78%	99.99%	71.57%
Diagnosis 7	Outpatient	76.55%	99.99%	99.99%	65.81%	79.69%	100.00%	100.00%	72.82%
Diagnosis 8	Inpatient	98.32%	99.39%	99.99%	77.14%	99.86%	99.76%	99.99%	71.57%
Diagnosis 8	Outpatient	83.41%	99.99%	100.00%	75.80%	88.28%	100.00%	100.00%	84.31%
Diagnosis 9	Inpatient	98.30%	99.34%	99.99%	77.14%	99.85%	99.74%	99.99%	71.57%
Diagnosis 9	Outpatient	87.30%	99.99%	100.00%	81.48%	91.89%	100.00%	100.00%	89.15%
Header Amount Billed	Inpatient	98.49%	97.71%	99.94%	95.61%	99.56%	99.21%	99.95%	96.81%
Header Amount Billed	Outpatient	58.47%	37.44%	99.65%	56.49%	58.16%	37.32%	99.36%	61.09%
Header Amount Paid	Inpatient	99.97%	99.95%	100.00%	99.95%	99.69%	99.43%	99.99%	96.64%

Institutional		Data Accuracy — Match Rate							
		Record Count Results				Paid Amount Results			
Field Name	Claim Form	Statewide	AHC	PHW	UPMC	Statewide	AHC	PHW	UPMC
Header Amount Paid	Outpatient	99.62%	98.75%	100.00%	99.78%	99.16%	97.79%	99.90%	99.49%
Header Copay Amount	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Header Medicare Paid	Inpatient	73.94%	95.26%	54.47%	14.18%	98.86%	99.34%	98.32%	78.76%
Header Medicare Paid	Outpatient	42.01%	34.06%	27.63%	46.85%	59.10%	80.16%	46.25%	54.23%
HFDOS	Inpatient	99.60%	99.64%	100.00%	96.45%	99.95%	99.90%	100.00%	99.57%
HFDOS	Outpatient	98.92%	99.30%	100.00%	98.61%	99.11%	98.38%	100.00%	99.26%
ICD-10 Procedure Code 1	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
ICD-10 Procedure Code 2	Inpatient	99.93%	100.00%	99.83%	100.00%	99.97%	100.00%	99.94%	100.00%
ICD-10 Procedure Code 3	Inpatient	99.91%	100.00%	99.77%	100.00%	99.96%	100.00%	99.92%	100.00%
ICD-10 Procedure Code 4	Inpatient	99.90%	100.00%	99.76%	100.00%	99.96%	100.00%	99.91%	100.00%
ICD-10 Procedure Code 5	Inpatient	99.91%	100.00%	99.77%	100.00%	99.96%	100.00%	99.91%	100.00%
ICD-10 Procedure Code 6	Inpatient	99.90%	100.00%	99.77%	100.00%	99.96%	100.00%	99.91%	100.00%
MCO Code	Inpatient	99.98%	100.00%	99.96%	100.00%	99.99%	100.00%	99.98%	100.00%
MCO Code	Outpatient	100.00%	100.00%	99.97%	100.00%	100.00%	100.00%	99.94%	100.00%
MCO DRG	Inpatient	96.26%	98.33%	93.01%	99.88%	99.22%	99.66%	98.72%	56.87%
MCO DRG Type	Inpatient	59.12%	72.46%	49.38%	5.04%	12.21%	18.29%	5.24%	49.10%
MCO Paid Date	Inpatient	97.86%	100.00%	95.06%	97.59%	98.72%	100.00%	97.25%	96.71%
MCO Paid Date	Outpatient	98.18%	100.00%	96.56%	97.99%	97.80%	100.00%	94.57%	97.41%
Modifier 1	Outpatient	95.46%	80.45%	98.91%	98.90%	92.03%	63.03%	99.11%	99.43%
Modifier 2	Outpatient	89.55%	96.35%	99.69%	85.81%	83.32%	95.67%	99.56%	78.89%
Modifier 3	Outpatient	99.50%	99.84%	99.96%	99.32%	99.48%	99.75%	99.98%	99.38%
Modifier 4	Outpatient	99.98%	99.99%	99.99%	99.98%	99.99%	99.99%	100.00%	99.99%
Present on Admission 1	Inpatient	88.19%	93.36%	94.08%	0.75%	85.73%	87.45%	83.78%	37.70%

Institutional		Data Accuracy — Match Rate							
		Record Count Results				Paid Amount Results			
Field Name	Claim Form	Statewide	AHC	PHW	UPMC	Statewide	AHC	PHW	UPMC
Present on Admission 10	Inpatient	86.35%	84.39%	98.31%	21.89%	93.75%	92.17%	95.56%	56.65%
Present on Admission 11	Inpatient	86.26%	83.80%	98.49%	24.41%	94.11%	92.40%	96.07%	66.28%
Present on Admission 12	Inpatient	87.13%	84.25%	99.96%	25.00%	97.71%	95.79%	99.92%	73.36%
Present on Admission 13	Inpatient	86.89%	83.67%	99.97%	26.18%	97.59%	95.57%	99.92%	80.28%
Present on Admission 14	Inpatient	86.73%	83.26%	99.97%	27.14%	97.61%	95.58%	99.94%	75.27%
Present on Admission 15	Inpatient	86.58%	82.87%	99.98%	28.10%	97.64%	95.63%	99.95%	64.08%
Present on Admission 16	Inpatient	86.65%	82.81%	99.98%	29.77%	97.44%	95.26%	99.95%	61.60%
Present on Admission 17	Inpatient	86.89%	83.09%	99.98%	31.28%	97.64%	95.61%	99.95%	91.04%
Present on Admission 18	Inpatient	87.11%	83.30%	99.98%	33.18%	97.63%	95.60%	99.96%	63.85%
Present on Admission 19	Inpatient	87.89%	84.23%	99.99%	37.87%	97.86%	96.03%	99.97%	61.96%
Present on Admission 2	Inpatient	88.74%	92.25%	96.46%	3.63%	90.85%	91.15%	90.53%	66.87%
Present on Admission 20	Inpatient	88.60%	84.96%	99.99%	43.32%	97.89%	96.08%	99.97%	91.61%
Present on Admission 21	Inpatient	89.52%	86.51%	99.99%	44.88%	98.16%	96.57%	99.98%	82.44%
Present on Admission 22	Inpatient	90.06%	87.30%	99.99%	46.67%	98.19%	96.62%	99.98%	92.58%
Present on Admission 23	Inpatient	90.62%	88.22%	99.99%	47.98%	98.27%	96.77%	99.98%	83.32%
Present on Admission 24	Inpatient	91.12%	89.06%	99.99%	48.71%	98.41%	97.04%	99.99%	93.67%
Present on Admission 25	Inpatient	89.13%	91.77%	90.97%	52.47%	98.07%	97.59%	98.64%	81.85%
Present on Admission 3	Inpatient	88.51%	91.36%	96.88%	4.90%	91.42%	91.14%	91.75%	59.95%
Present on Admission 4	Inpatient	88.38%	90.43%	97.07%	9.87%	91.72%	91.27%	92.25%	80.36%
Present on Admission 5	Inpatient	88.23%	89.61%	97.35%	12.92%	92.13%	91.35%	93.03%	61.00%
Present on Admission 6	Inpatient	87.98%	88.79%	97.52%	14.84%	92.51%	91.65%	93.51%	68.32%
Present on Admission 7	Inpatient	87.50%	87.66%	97.73%	15.65%	92.80%	91.73%	94.03%	64.10%
Present on Admission 8	Inpatient	87.36%	86.83%	97.91%	19.56%	92.99%	91.72%	94.45%	75.72%

Institutional		Data Accuracy — Match Rate							
		Record Count Results				Paid Amount Results			
Field Name	Claim Form	Statewide	AHC	PHW	UPMC	Statewide	AHC	PHW	UPMC
Present on Admission 9	Inpatient	86.71%	85.44%	98.11%	19.85%	93.31%	91.85%	94.98%	52.56%
Recipient ID Number	Inpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Recipient ID Number	Outpatient	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Revenue Code	Outpatient	93.75%	69.06%	99.14%	99.46%	90.15%	53.83%	99.73%	99.38%
Type of Admission	Inpatient	99.97%	100.00%	100.00%	99.52%	100.00%	100.00%	100.00%	99.94%
Type of Admission	Outpatient	100.00%	100.00%	100.00%	99.99%	100.00%	100.00%	100.00%	100.00%
Type of Bill	Inpatient	41.79%	0.00%	92.14%	74.82%	45.06%	0.00%	96.56%	88.15%
Type of Bill	Outpatient	72.96%	0.00%	91.37%	89.34%	70.50%	0.00%	93.77%	88.12%

Table A-8: Data Accuracy: Professional

Professional	Data Accuracy — Match Rate							
	Record Count Results				Paid Amount Results			
Field Name	Statewide	AHC	PHW	UPMC	Statewide	AHC	PHW	UPMC
Approved/Rejected Indicator	97.14%	97.25%	96.70%	97.24%	99.96%	99.95%	99.99%	99.94%
Billing Provider NPI	99.93%	99.93%	99.88%	99.95%	99.89%	99.96%	99.63%	99.96%
Capitation FFS Indicator	92.17%	92.19%	96.28%	88.76%	93.63%	93.22%	99.89%	88.95%
CPT/HCPCS Procedure Code	99.47%	99.07%	99.88%	100.00%	99.93%	99.89%	99.97%	100.00%
Detail Amount Paid	98.97%	98.83%	99.66%	98.71%	99.29%	99.51%	99.77%	98.35%
Detail Copay Amount	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Detail Medicare Paid	93.50%	99.24%	83.38%	89.27%	99.65%	99.87%	99.28%	99.47%
DFDOS	99.79%	99.62%	99.98%	100.00%	99.95%	99.91%	99.99%	100.00%
Diagnosis 1	99.99%	100.00%	99.98%	99.97%	100.00%	100.00%	100.00%	99.99%
Diagnosis 2	99.97%	99.98%	99.98%	99.94%	99.99%	99.99%	100.00%	99.97%
Diagnosis 3	99.98%	99.99%	99.99%	99.97%	99.99%	100.00%	100.00%	99.98%
Diagnosis 4	99.99%	99.99%	99.99%	99.99%	100.00%	100.00%	100.00%	99.99%
Diagnosis 5	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.99%
Diagnosis 6	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.99%
Diagnosis 7	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.99%
Diagnosis 8	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.99%
Diagnosis 9	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.99%
Diagnosis 10	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.99%
Diagnosis 11	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.99%

Professional	Data Accuracy — Match Rate							
	Record Count Results				Paid Amount Results			
Field Name	Statewide	AHC	PHW	UPMC	Statewide	AHC	PHW	UPMC
Diagnosis 12	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.99%
Header Amount Billed	93.20%	89.45%	99.59%	96.16%	94.76%	91.13%	99.96%	98.33%
Header Amount Paid	99.37%	99.58%	99.62%	98.70%	99.64%	99.86%	99.97%	98.86%
Header Copay Amount	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Header Medicare Paid	89.63%	93.83%	79.88%	88.45%	99.35%	99.37%	99.25%	99.42%
HFDOS	99.92%	99.89%	99.96%	99.93%	99.96%	99.97%	99.97%	99.92%
MCO Code	99.99%	99.99%	99.97%	100.00%	99.99%	99.99%	99.98%	100.00%
MCO Paid Date	96.68%	100.00%	98.40%	87.97%	96.83%	100.00%	98.74%	87.93%
Modifier 1	99.68%	99.73%	99.70%	99.54%	99.93%	99.96%	99.93%	99.85%
Modifier 2	99.86%	99.90%	99.81%	99.83%	99.97%	99.98%	99.96%	99.95%
Modifier 3	99.97%	99.98%	99.96%	99.97%	99.99%	100.00%	99.99%	99.99%
Modifier 4	99.99%	100.00%	99.99%	99.99%	100.00%	100.00%	100.00%	100.00%
Performing Provider NPI	80.15%	87.01%	38.60%	99.39%	78.36%	89.84%	25.78%	99.48%
POS	99.33%	99.65%	98.48%	99.33%	99.85%	99.88%	99.78%	99.85%
Recipient ID Number	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Table A-9: Data Accuracy: Pharmacy

Pharmacy	Data Accuracy — Match Rate							
	Record Count Results				Paid Amount Results			
Field Name	Statewide	AHC	PHW	UPMC	Statewide	AHC	PHW	UPMC
Approved/Rejected Indicator	98.49%	99.58%	94.70%	99.33%	99.89%	99.81%	100.00%	99.97%
Billing Provider NPI	99.79%	99.60%	100.00%	99.99%	99.20%	98.58%	100.00%	99.99%
Compound Prescription Indicator	43.56%	0.00%	86.71%	91.84%	35.90%	0.00%	86.51%	79.12%
DAW	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Days Supply	94.20%	98.54%	86.71%	91.80%	88.75%	93.97%	86.51%	79.10%
Diagnosis 1	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Diagnosis 2	98.97%	100.00%	100.00%	96.30%	97.43%	100.00%	100.00%	90.26%
Diagnosis 3	99.12%	100.00%	100.00%	96.82%	98.21%	100.00%	100.00%	93.24%
Diagnosis 4	99.20%	100.00%	100.00%	97.12%	98.50%	100.00%	100.00%	94.32%
Diagnosis 5	99.31%	100.00%	100.00%	97.51%	98.93%	100.00%	100.00%	95.93%
Diagnosis 6	99.39%	100.00%	100.00%	97.79%	99.11%	100.00%	100.00%	96.64%
Diagnosis 7	99.48%	100.00%	100.00%	98.13%	99.34%	100.00%	100.00%	97.49%
Diagnosis 8	99.56%	100.00%	100.00%	98.41%	99.54%	100.00%	100.00%	98.26%
Diagnosis 9	99.63%	100.00%	100.00%	98.65%	99.68%	100.00%	100.00%	98.78%
Diagnosis 10	99.68%	100.00%	100.00%	98.83%	99.80%	100.00%	100.00%	99.26%

Pharmacy	Data Accuracy — Match Rate							
	Record Count Results				Paid Amount Results			
Field Name	Statewide	AHC	PHW	UPMC	Statewide	AHC	PHW	UPMC
Diagnosis 11	99.71%	100.00%	100.00%	98.97%	99.88%	100.00%	100.00%	99.56%
Diagnosis 12	99.76%	100.00%	100.00%	99.12%	99.93%	100.00%	100.00%	99.75%
Header Amount Billed	20.29%	3.77%	86.97%	0.55%	19.79%	7.38%	88.94%	0.90%
Header Amount Paid	71.57%	99.33%	93.14%	3.73%	70.78%	95.70%	90.70%	4.71%
Header Copay Amount	99.74%	99.98%	98.84%	99.98%	99.09%	100.00%	94.82%	99.95%
Header Medicare Paid	97.48%	99.94%	91.27%	97.60%	97.26%	99.86%	91.79%	95.33%
HFDOS	98.45%	99.93%	94.14%	98.94%	98.95%	99.95%	97.81%	97.56%
MCO Code	100.00%	100.00%	100.00%	100.00%	99.99%	99.99%	100.00%	99.99%
MCO Paid Date	29.06%	8.25%	12.97%	79.87%	33.31%	12.38%	12.85%	91.24%
NDC	98.32%	99.97%	92.05%	100.00%	99.19%	99.99%	95.37%	100.00%
Prescriber NPI	94.22%	98.54%	86.71%	91.88%	88.77%	93.97%	86.51%	79.19%
Prior Authorization Type	65.66%	95.10%	80.20%	0.00%	41.94%	58.59%	51.89%	0.00%
Quantity Dispensed	94.53%	96.99%	92.09%	91.82%	87.37%	89.59%	92.95%	79.00%
Recipient ID Number	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

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